

PLACE OF DEATH

Middlesex

(County)

Marlborough

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

21

Registered No. # 2

No. Marlboro Hospital

{(If death occurred in a hospital or institution,  
St. } give its NAME instead of street and number)

2 FULL NAME Judith (McGrail) Pettirossi

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR.)

63 Deerfoot

Southborough, Mass.

(a) Residence. No. (Usual place of abode)

4 (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 15, 1971

(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Stab wound of chest into the heart

5 Accident, suicide, or homicide (specify) Suicide

Date and hour of injury 9:00p.m. Jan. 14, 71

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? Southboro, Mass. home

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home

(Specify type of place)

Manner of Injury Selfinflicted knife wound

(How did injury occur?)

Nature of Injury Laceration chest &amp; heart

no yes

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Kenneth R. Greenleaf, M. D.

(Address) Sudbury, Mass. Jan. 15 71

7 St. John's Cem. Worcester, Mass.

Place of Burial or Cremation. January 18 (City or Town) 71

DATE OF BURIAL 19

8 NAME OF FUNERAL DIRECTOR Callahan Bros.

ADDRESS Worcester, Mass.

Received and filed January 15, 1971 71

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Married

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife, in full)

Albert Pettirossi

(or) WIFE of (Husband's name in full)

13 AGE 36

Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

14 Usual

Physical therapist

(Kind of work done during most of working life)

15 Industry or Business:

School Dept.

16 Social Security No. 020 26 4535

17 BIRTHPLACE (City) (State or country)

Worcester, Mass.

18 NAME OF FATHER

Thomas McGrail

19 BIRTHPLACE OF FATHER (City) (State or country)

Worcester, Mass.

20 MAIDEN NAME OF MOTHER

Mary Cunningham

21 BIRTHPLACE OF MOTHER (City) (State or country)

Worcester, Mass.

22 Informant (Address) Albert Pettirossi

63 Deerfoot Rd. Southboro, Mass.

A TRUE COPY

Peter P. Cottone

ATTEST: (Registrar of City or Town where death occurred)

Agent

Jan. 16, 1971

DATE FILED 19

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-3-62-932695

PLACE OF DEATH

Middlesex

(County)

Marlborough

(City or Town)

Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

Registered No. 20  
# 1

No. Marlboro Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Royce K. Whittier (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence No. 154 Marlboro Road St. Southboro, Mass. (Usual place of abode) 3 hours (If nonresident, give city or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 15, 1971 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.) arteriosclerotic heart disease

5 Accident, suicide, or homicide (specify) no Date and hour of injury 19.

IF ACCIDENTAL, was injury causally related to the death? Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?) Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) Kenneth Greenleaf M. D.

(Address) Sudbury, Mass. Date Jan. 17 71

7 North Amherst Ceme. Amherst, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 18 19 71

8 NAME OF FUNERAL DIRECTOR Donald C. Morris ADDRESS 40 Main St. Southboro, Mass.

Received and filed January 22, 1971

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of Gertrude McKenna (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

13 AGE 65 7 0 If under 24 hours AGE Years Months Days Hours Minutes

14 Usual Occupation: Carpenter (Kind of work done during most of working life)

15 Industry or Business: Building

16 Social Security No. 017 05 7893

17 BIRTHPLACE (City) Amherst, Mass. (State or country)

18 NAME OF FATHER Arthur B. Whittier

19 BIRTHPLACE OF FATHER (City) Calais, Maine (State or country)

20 MAIDEN NAME OF MOTHER Anna Knight

21 BIRTHPLACE OF MOTHER (City) Amherst, Mass. (State or country)

22 Informant Mrs. Gertrude Whittier (Address)

154 Marlboro Rd. Southboro, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED January 19 19 71



FORM R-301

be filed for burial permit  
with Board of Health  
or its Agent.

INSTRUCTIONS  
FOR  
MEDICAL CERTIFICATE

PRINT OR TYPE  
CAUSE OR CAUSES  
OF DEATH

do not enter  
more than one  
cause for each  
of (a), (b) and (c)

This does not mean  
the mode of dying,  
such as heart failure,  
asthenia, etc. It means  
the disease, or complica-  
tions which caused  
death.

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

Conditions contrib-  
uting to death but not  
related to the terminal  
disease condition given  
in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Worcester

(County)

Southboro

(City or Town)

No. 18 Gilmore Road

STANDARD  
CERTIFICATE OF DEATH

Registered No. # 3

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Robert E. Kay  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, WWII  
if so specify WAR)

(a) Permanent Residence. No. 18 Gilmore Road st. Southboro, Mass.  
(City or town and State)

Length of stay: In place of death, 10 years months days. In place of residence, 10 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 25 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Sept 8, 1964, to Jan. 25, 1971.  
I last saw him alive on Jan. 22, 1971, death is said to  
have occurred on the date stated above, at 3:15 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma, Sigmoid Colon

(b) Due To

(c) Due To

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONSINTERVAL  
BETWEEN  
ONSET AND  
DEATH

14 mos.

Was autopsy performed? No  
What test confirmed diagnosis? Laparotomy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone, M. D.  
(Print or Type Name)  
(Address) 42 Main, Southboro Date Jan. 26, 1971

6 Restland Mem. Park Hanover, N.J.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 28, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS 40 Main Street, Southboro, Mass.

Received and filed January 29, 1971

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Rae T. Albert  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 55 Years 9 Months 24 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Insurance Mgr.  
(Kind of work done during most of working life)

14 Industry or Business Prudential Ins. Co.

15 Social Security No. 137-05-0915

16 BIRTHPLACE (City) Irvington N.J.  
(State or country)

17 NAME OF FATHER Grant. U.S. Kay

18 BIRTHPLACE OF FATHER (City) Harrison N.J.  
(State or country)

19 MAIDEN NAME OF MOTHER Sadie Remington

20 BIRTHPLACE OF MOTHER (City) Newark N.J.  
(State or country)

21 Informant Mrs. Robert E. Kay  
18 Gilmore Road, Southboro, Mass.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

(Official Designation)

(Date of Issue of Permit)



**SPACE FOR ADDITIONAL INFORMATION** .....

**DATE OF ENTERING MILITARY SERVICE** Jan. 16, 1943 .....

**DATE OF DISCHARGE** Dec. 6, 1945 .....

**RANK, RATING** S. Sgt. ....

**ORGANIZATION AND OUTFIT** Signal Corps 33rd Bn. ....

**SERVICE NUMBER** 32-606-313 .....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) Attending physicians will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) Board of Health physicians will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. # 4

No. Framingham Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Mildred W. Wadsworth (If deceased is a married, widowed or divorced woman, give also maiden name.) (If deceased a U. S. War Veteran, specify WAR)

(a) Permanent Residence, No. 29 Oak Hill Rd. St. Southboro, Mass. (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 28, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Feb. 29, 1968, to Jan. 28, 1971.  
I last saw her alive on Jan. 27, 1971, death is said to have occurred on the date stated above, at 2:15 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerosis, cerebral

Due To (b) Arteriosclerosis, general Yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus 4Yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical course

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 1/28, 1971

6 Mt. Auburn Cem., Hopkinton, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 31, 1971

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth  
ADDRESS Framingham, Mass.

8 Informant Gertrude Wadsworth  
(Address) 84 Myrtle St., Ashland, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 77 Years 5 Months 25 Days | If under 24 hours Hours Minutes

14 Usual Occupation Librarian (Kind of work done during most of working life)

15 Industry or Business Colleges

16 Social Security No. 033-34-1333T

17 BIRTHPLACE (City) Hopkinton, Mass. (State or country)

18 NAME OF FATHER Nathan Frederick Wadsworth

19 BIRTHPLACE OF FATHER (City) Hopkinton, Mass. (State or country)

20 MAIDEN NAME OF MOTHER Jennie Hewes

21 BIRTHPLACE OF MOTHER (City) Boston, Mass. (State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Feb. 1, 1971

Received and filed February 19, 1971

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #6

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Attilio Baldini (If deceased is a married, widowed or divorced woman, give also maiden name.) (If deceased a U. S. War Veteran, specify WAR) WW 1

(a) Permanent Residence. No. 34 Oak Hill Rd., St. Southboro, Mass. (City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 3, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from 9-22, 1971, to 2-3, 1971.  
I last saw him alive on 2-1, 1971, death is said to have occurred on the date stated above, at 11:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute coronary thrombosis 4hrs

Due To (b) Angina pectoris 1 yr

Due To (c) Gastrointestinal bleeding cause undetermined 5yrs

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? EKG & Physical exam

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) Thomas J. Carnicelli, M.D.

(Address) Framingham Date 2-4, 1971

St. Mary's Cemetery, Mansfield  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 6, 1971

7 NAME OF FUNERAL DIRECTOR Shierino A. Amici

ADDRESS Mansfield, Mass.

8 Informant Mrs. Gladys Baldini

(Address) 34 Oak Hill Rd., Southboro

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of Gladys C. Scarnano (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 75 Years 1 Months 29 Days If under 24 hours Hours Minutes

14 Usual Occupation Store proprietor (Kind of work done during most of working life)

15 Industry or Business Baldini's Market

16 Social Security No.

17 BIRTHPLACE (City) Italy (State or country)

18 NAME OF FATHER Augusto Baldini

19 BIRTHPLACE OF FATHER (City) Italy (State or country)

20 MAIDEN NAME OF MOTHER Altavilla Vagini

21 BIRTHPLACE OF MOTHER (City) Italy (State or country)

A TRUE COPY Michael J. Ward

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 2-8-71 19

Received and filed February 26, 1971

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



SERVICE NUMBER ..... #100#75

3-28-18

4-12-18

Pvt.

4th Co. 1st Bn. D.B.

#100#75



To be filed for burial permit  
with Board of Health  
or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT  
OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of  
information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF  
DEATH in plain terms, so that it may be properly classified under the International Classification of Causes  
of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114,  
§§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-3-67-944817

PLACE OF DEATH

Worcester  
(County)

Southborough  
(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. #5

No. 11 Willow Street

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME Joseph A Fantony  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran, (if so specify WAR) WWII

(a) Permanent Residence. No. 11 Willow St. Southborough, Mass.  
(City or town and State)

Length of stay: In place of death 10 years months days. In place of residence 19 years 1 months 29 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 22 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease, pro-  
surally coronary thrombosis (Found  
dead in home)

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did  
injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place?

(Specify type of place)

Manner of  
injury

(How did injury occur?)

Nature of  
injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) S. Alden Guild M.D.

(Print or Type Name) S. Alden Guild M.D.

(Address) Glatton Date Feb 23 1971

7 Rural cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 26 1971

8 NAME OF FUNERAL DIRECTOR Donald C. Morris  
40 Main Street, Southboro, Mass.  
ADDRESS

Received and filed February 26 1971

A TRUE COPY ATTEST: (Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR White 11 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of Charlotte McGovern  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 19 Years 1 Months 29 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: N.E. Telephone Installer  
(Kind of work done during most of working life)

15 Industry or Business: New England Telephone Co

16 Social Security No. 020-12-2644

17 BIRTHPLACE (City) Framingham  
(State or country) Mass.

18 NAME OF FATHER Charles Fantony

19 BIRTHPLACE OF FATHER (City) Ispra  
(State or country) Italy

20 MAIDEN NAME OF MOTHER Mary E. Mitchell

21 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.

22 Informant Steven Fantony  
(Address)

11 Willow Street, Southboro, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Anna S. ... (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 2-24-71



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE .....8-21-1942.....  
DATE OF DISCHARGE .....2-5-1946.....  
RANK, RATING .....Coxswain.....  
ORGANIZATION AND OUTFIT .....U.S. Coast Guard.....  
SERVICE NUMBER .....594-327.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

#### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Worcester

(County)

Southborough

(City or Town)

No. 99 Pine Hill Road

STANDARD

CERTIFICATE OF DEATH

Registered No. # 8

St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(If deceased a

U. S. War Veteran,

specify WAR)

No

(a) Permanent Residence. No. 99 Pine Hill Road St. Southborough, Mass.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 2 - 23 - 71  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Jan. 13, 1956, to Feb. 23, 1971.  
I last saw her alive on Feb. 18, 1971, death is said to have occurred on the date stated above, at 7 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIOSCLEROTIC HEART DISEASE  
Aortic Stenosis

Due To

(b) HYPERTENSION

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

OBESITY

Was autopsy performed? No, No.  
What test confirmed diagnosis? clinical course

5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify No.

(Signature) Timothy P. Stone, M. D.  
(Print or Type Name)  
(Address) 42 Main, Southboro Date FEB 24 1971

6 Newton Crematory Newton, Mass.  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL February 25 1971

7 NAME OF FUNERAL DIRECTOR Cookson Funeral Home, Inc.  
ADDRESS 318 Union Ave., Framingham

8 Informant Mr. Paul D. Bragg  
(Address) 99 Pine Hill Rd., Southborough

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED Married

12 If married, widowed, or divorced  
HUSBAND of

(or) WIFE of Paul D. Bragg  
(Give maiden name of wife in full)  
(Husband's name in full)

13 AGE 80 Years 1 Months 13 Days If under 24 hours Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. None

17 BIRTHPLACE (City) Aberdeen  
(State or country) Scotland

18 NAME OF FATHER John Birnie

19 BIRTHPLACE OF FATHER (City) Aberdeenshire  
(State or country) Scotland

20 MAIDEN NAME OF MOTHER Mary Milne

21 BIRTHPLACE OF MOTHER (City) Aberdeen  
(State or country) Scotland

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent Board of Health or other)

(Official Designation) 2-25-71  
(Date of Issue of Permit)

Received and filed March 8, 1971

Town Clerk (Registrar)

A TRUE COPY ATTEST:

FORM R-301

Filed for burial permit with Board of Health or its Agent.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

PRINT OR TYPE CAUSE OR CAUSES OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, pneumonia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).



FORM R-301

be filed for burial permit  
with Board of Health  
or its Agent.

INSTRUCTIONS  
FOR  
MEDICAL CERTIFICATE

PRINT OR TYPE  
CAUSE OR CAUSES  
OF DEATH

do not enter  
more than one  
cause for each  
of (a), (b) and (c)

This does not mean  
the mode of dying,  
such as heart failure,  
asthenia, etc. It means  
the disease, or complica-  
tions which caused  
death.

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

Conditions contrib-  
uting to death but not  
related to the terminal  
disease condition given  
in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS



PLACE OF DEATH

1

Worcester

(County)

Southboro

(City or Town)

No. 22 Edgewood Road

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

Registered No.

# 7

STANDARD  
CERTIFICATE OF DEATH

PHYSICIAN — IMPORTANT

2 FULL NAME Mary E. (McLaughlin) Kiley

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, None  
if so specify WAR)

(a) Permanent Residence. No. 22 Edgewood Road

St. Southboro, Mass.

(City or town and State)

Length of stay: In place of death 1 1/2 years months days. In place of residence 1 1/2 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 28 1971  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
SEPT 18 1950, to FEB 28 1971.I last saw him alive on FEB 26 1971, death is said to  
have occurred on the date stated above, at 6:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Emphysema

(b) Due To Pulmonary Fibrosis

(c) Due To Chronic Bronchitis

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? X-Ray

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone, M. D.

TIMOTHY P. STONE

(Print or Type Name)

(Address) 42 MAIN STREET, SOUTHBORO Date MAR 1 1971

6 Rural Cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 2 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street  
ADDRESS Southboro, Mass.

Received and filed March 3, 1971

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Arthur J. Kiley  
(Husband's name in full)12 AGE 79 Years 7 Months 14 Days If under 24 hours  
Hours Minutes13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business At Home

15 Social Security No. 017-40-8643 J1

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER Robert McLaughlin

18 BIRTHPLACE OF FATHER (City) CNBL  
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen McLaughlin

20 BIRTHPLACE OF MOTHER (City) CNBL  
(State or country) Ireland21 Informant Arthur J. Kiley  
22 Edgewood Road, Southboro, Mass.  
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



be filed for burial permit  
with Board of Health  
or its Agent.

INSTRUCTIONS  
FOR  
MEDICAL CERTIFICATE

PRINT OR TYPE  
CAUSE OR CAUSES  
OF DEATH

do not enter  
more than one  
cause for each  
of (a), (b) and (c)

This does not mean  
the mode of dying,  
such as heart failure,  
asthenia, etc. It means  
the disease, or complica-  
tions, which caused  
death.

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

Conditions contrib-  
uting to death but not  
related to the terminal  
disease condition given  
in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS



Worcester  
(County)

Southboro  
(City or Town)

No. 261 Cordaville Road

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

Registered No. # 9

STANDARD  
CERTIFICATE OF DEATH

PHYSICIAN — IMPORTANT

2 FULL NAME Antonio Giombetti

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, None  
if so specify WAR)

(a) Permanent Residence. No. 261 Cordaville Road

s. Southboro, Mass.

(City or town and State)

Length of stay: In place of death 50 years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 6 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Dec 18 1965 to Mar 6 1971

I last saw him live on Feb. 11 1971, death is said to

have occurred on the date stated above, at 12.50 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Thrombosis

Due To Hypertensive Arteriosclerosis

(b) Heart Disease

Due To

(c) Overweight

OTHER  
SIGNIFICANT  
CONDITIONS

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

5 min

5 yrs

5 yrs

Was autopsy performed? No  
What test confirmed diagnosis? clinical course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone M. D.

(Print or Type Name)

(Address) 42 Main Street Southboro Date Mar 7 1971

Rural Cemetery Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 8 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main Street Southboro, Mass.

Received and filed March 8 1971

Paul J. Berry Town Clerk (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Marie Finnoch Giombetti (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 22 Years 8 Months 7 Days If under 24 hours Hours Minutes

13 Usual Occupation Shoeworker Retired (Kind of work done during most of working life)

14 Industry or Business Shoe Industry

15 Social Security No. 017-05-7058

16 BIRTHPLACE (City) Mondolpo (State or country) Italy

17 NAME OF FATHER Ralpheo Giombetti

18 BIRTHPLACE OF FATHER (City) Mondolpo (State or country) Italy

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) Mondolpo (State or country) Italy

Miss Yola Giombetti

21 Informant 261 Cordaville Road, Southboro, Mass (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

(Official Designation) (Date of Issue of Permit)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Marlborough  
(City or Town making this return)  
# 14

PLACE OF DEATH

Middlesex  
(County)

Marlborough  
(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 114

No. Marlboro Hospital

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Mary A. (Alderson) Baker  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran, no  
specify WAR)

(a) Permanent Residence, No. 100 Newton

St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 8, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
April 6, 1971, to April 8, 1971  
I last saw her alive on April 7, 1971. Death is said to  
have occurred on the date stated above, at 1:15a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) respiratory failure

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

5 wks

Due To

(b) carcinoma of pancreas

6 mos

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? surgery

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

John D. Nicholson

(Attending Physician) M.D.

(Address) Sudbury, Mass. Date Apr. 9, 1971

6 Rural Crematory, Worcester, Mass. (City or Town)

Place of Burial or Cremation

DATE OF BURIAL April 10, 1971

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St. Marlboro, Mass.

8 Informant Edward A. Baker - son

(Address) Adle Nable Dr. Chester, N.Y.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Female

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Widowed

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Clarence Edward Baker

(Husband's name in full)

13 AGE 70 Years 3 Months 20 Days

If under 24 hours  
Hours Minutes

14 Usual

Occupation

Registered Nurse

(Kind of work done during most of working life)

15 Industry

or Business

Hospital

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Middletown, Connecticut

18 NAME OF FATHER

Edward Alderson

19 BIRTHPLACE OF FATHER (City)

(State or country)

England

20 MAIDEN NAME OF MOTHER

Joanna Turpie

21 BIRTHPLACE OF MOTHER (City)

(State or country)

Scotland

PARENTS

A TRUE COPY

ATTEST: Peter P. Cottone

(Registrar of City or Town where death occurred)

Agent

April 8, 1971

DATE FILED

19

Received and filed May 14, 1971

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. # 13

No. Framingham Union Hospital St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Arthur R. Joyce  
(If deceased is a married, widowed or divorced woman, give also maiden name.) { (If deceased a U. S. War Veteran, specify WAR) WWII

(a) Permanent Residence, No. 89 Worcester Rd. St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 11, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from 3/16 to 4/11 71  
I last saw him live on 4/11 71 death is said to have occurred on the date stated above, at 4:27 AM m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

Due To (b) Amyotrophic lateral sclerosis

Due To (c) OTHER SIGNIFICANT CONDITIONS  
Gastrointestinal bleeding

INTERVAL BETWEEN ONSET AND DEATH

3 Wks.

3 Yrs.

2 Wks.

Was autopsy performed? No  
What test confirmed diagnosis? XRay, electromyogram

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

Arthur Safran  
(Attending Physician) M.D.

(Address) Framingham, Mass. Date 4/11 71

6 St. Stephen's Cem., Framingham, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 14, 1971

7 NAME OF FUNERAL DIRECTOR DePasquale Funeral Home  
ADDRESS Milford, Mass.

8 Informant Mrs. Anne Marie Joyce  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of Anne Marie LeMonde  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 60 Years 5 Months 28 Days | If under 24 hours Hours Minutes

14 Usual Occupation Shoe worker  
(Kind of work done during most of working life)

15 Industry or Business Shoe industry

16 Social Security No. 025-03-4843

17 BIRTHPLACE (City) Boston, Mass.  
(State or country)

18 NAME OF FATHER Edwin Joyce

19 BIRTHPLACE OF FATHER (City) Maine  
(State or country)

20 MAIDEN NAME OF MOTHER Etta White

21 BIRTHPLACE OF MOTHER (City) Gloucester, Mass.  
(State or country)

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED Apr. 21, 1971

Received and filed May 12, 1971

(Registrar of City or Town where deceased resided)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... April 28, 1944

DATE OF DISCHARGE ..... May 8, 1946

RANK, RATING ..... P.F.C. Military Police

ORGANIZATION AND OUTFIT ..... U.S.A.

SERVICE NUMBER ..... 31-405-675

SERVICE NUMBER .....



for burial permit  
ard of Health  
ts Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
se, or compli-  
which caused

ions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
o the terminal  
condition given

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #10

PLACE OF DEATH

Worcester  
(County)

Southborough  
(City or Town)

No. 31 Flagg Road

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Allen E. Cox  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran, WWII  
if so specify WAR)

(a) Permanent Residence. No. 31 Flagg Road St. Southborough, Mass.

(City or town and State)

Length of stay: In place of death 11 years.....months.....days. In place of residence 11 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 22 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
April 14, 1968 to April 22, 1971

I last saw him alive on April 21, 1971, death is said to  
have occurred on the date stated above, at 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Subarachnoid hemorrhageINTERVAL  
BETWEEN  
ONSET AND  
DEATH18 hrs

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONSArteriosclerotic Heart Disease 3 yrsWas autopsy performed? NoWhat test confirmed diagnosis? Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify -

(Signature) Timothy P. Stone, M. D.  
TIMOTHY P. STONE  
(Print or Type Name)

(Address) 42 Main St., Southboro Date April 22, 1971

6 Rural Cemetery Southborough, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24, 19717 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street  
ADDRESS Southboro, Mass.

Received and filed 4/28/71, 1971

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Mary Jameson  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE 47 Years 2 Months 21 Days  
If under 24 hours  
.....Hours.....Minutes

13 Usual Occupation Consulting Engineer  
(Kind of work done during most of working life)

14 Industry or Business: Read-Cox

15 Social Security No. 459-18-2610

16 BIRTHPLACE (City) Duluth  
(State or country) Minn.

17 NAME OF FATHER Ernest J. Cox

18 BIRTHPLACE OF FATHER (City) Chippewa Falls  
(State or country) Wisc.

19 MAIDEN NAME OF MOTHER Minnie Uehren

20 BIRTHPLACE OF MOTHER (City) Chippewa Falls  
(State or country) Wisc.

21 Informant Mrs. Mary (Jameson) Cox  
31 Flagg Rd. Southborough, Mass.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Sena A. O'Connell, Agent  
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



**SPACE FOR ADDITIONAL INFORMATION** .....  
**DATE OF ENTERING MILITARY SERVICE**.....1943  
**DATE OF DISCHARGE**.....March.....1946  
**RANK, RATING**.....T/4.....  
**ORGANIZATION AND OUTFIT**.....1254 Engineer Combat Bn.....  
**SERVICE NUMBER**.....37...553...016.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



FORM R-303

Filed for burial permit  
with Board of Health  
or its Agent.

NOTE: CHAPTER 137, ACTS OF 1934, REQUIRES PHYSICIANS TO FURNISH OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 36, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100K-3-67-944817

PLACE OF DEATH

Middlesex  
(County)

Marlborough  
(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. #12

No. DOA at Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
2 FULL NAME Michael J. Crane (First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. 66 Main Street Southborough, Mass.  
(City or town and State)

Length of stay: In place of death years months DOA days. In place of residence 4 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 24, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
Asphyxiation By Hanging  
(Suicidal)

5 Accident, suicide, or homicide (specify) The Suicide

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) M. D.

(Address) 640 3/4 St. Middlesex Date 4-24-1971

7 St. Josephs Cemetery Dolgeville NY  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 28 1971

8 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 10 Main St. Southborough Mass

Received and filed 4/28/71

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR White 11 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of Edna Sandra Eddy (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

13 AGE 28 Years 1 Months 10 Days If under 24 hours Hours Minutes

14 Usual Occupation: Field Engineer (Kind of work done during most of working life)

15 Industry or Business: Gilbane Bldg. Co Boston

16 Social Security No. 077-34-9533

17 BIRTHPLACE (City) Little Falls (State or country) N.Y.

18 NAME OF FATHER Edward M. Crane

19 BIRTHPLACE OF FATHER (City) Dolgeville (State or country) N.Y.

20 MAIDEN NAME OF MOTHER Carrie VanAllen

21 BIRTHPLACE OF MOTHER (City) Middlesprite (State or country) N.Y.

22 Informant Mrs. Michael J. Crane (Address)

66 Main Street Southborough, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Suma a local Agent  
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 4-26-71



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

SOUTH BORO  
(City or Town making this return)

1 PLACE OF DEATH

WORCESTER  
(County)

SOUTH BORO  
(City or Town)

No. 18 OAK HILL ROAD

## STANDARD CERTIFICATE OF DEATH

Registered No. #11

§b (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JEAN HENRIETTA (GRAHAM) SKILLINGS  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) NO

(a) Permanent Residence. No. 18 OAK HILL ROAD St. SOUTH BORO MASS  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 24, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from April 8, 1956, to April 24, 1971.  
I last saw her alive on March 3, 1970, death is said to have occurred on the date stated above, at 6:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Aortic Stenosis

Due To

(b) Arteriosclerotic Heart Disease, 14 yrs.

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Hospital studies.

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone, M. D.  
(Print or Type Name)

(Address) 42 Main St, Southboro Date April 24, 1971

6 HOLTON ST CEM Danvers Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APR 27 1971

7 NAME OF FUNERAL DIRECTOR ROBERT K WADSWORTH  
108 LINCOLN ST.  
ADDRESS FRAMINGHAM, MASS 01701

8 Informant MRS IMogene S. ERICKSON (daughter)  
18 OAK HILL ROAD SOUTH BORO, MASS  
(Address)

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX FEMALE 10 COLOR WHITE 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of CHARLES FOLSOM SKILLINGS (Husband's name in full)

13 AGE 85 Years 10 Months 30 Days If under 24 hours Hours Minutes

14 Usual Occupation HOUSEWORK (Kind of work done during most of working life)

15 Industry or Business: AT HOME

16 Social Security No. 033-18-9719 D

17 BIRTHPLACE (City) (State or country) Ireland

18 NAME OF FATHER CNBL GRAHAM

19 BIRTHPLACE OF FATHER (City) (State or country) CNBL IRELAND

20 MAIDEN NAME OF MOTHER ELIZABETH CNBL

21 BIRTHPLACE OF MOTHER (City) (State or country) CNBL IRELAND

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent Board of Health or other) (Official Designation) (Date of Issue of Permit)

Received and filed April 26 1971

Paul J. Berry (Registrar)

A TRUE COPY ATTEST:

Skilling's.

R-301

for burial permit  
ard of Health  
ts Agent.

RUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
use, or compli-  
which caused

ons, if any,  
gave rise to  
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cause last.

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death but not  
o the terminal  
condition given



ed for burial permit  
Board of Health  
its Agent.

STRUCTIONS  
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a, etc. It means  
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g the under-  
cause lost.

ditions contrib-  
o death but not  
to the terminal  
condition given

## OUT - OF - TOWN The Commonwealth of Massachusetts

BOSTON

PLACE OF DEATH

Suffolk  
(County)Boston  
(City or Town)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return) # 16

STANDARD  
CERTIFICATE OF DEATH

Registered No. 4316

No. New England Baptist Hosp St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME Barton, Mary E. Mrs.  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 116 Main St. St. Southboro, Mass.  
(City or town and State)

Length of stay: In place of death 15 years 15 months 15 days. In place of residence 15 years 15 months 15 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 13 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
April 28, 1971, to May 13, 1971.  
I last saw him alive on May 13, 1971 death is said to  
have occurred on the date stated above, at 9:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MENINGITIS

(b) Due To

(c) Due To

(d) Due To

(e) Due To

OTHER SIGNIFICANT CONDITIONS CARCINOMA OF BREAST, METASTATIC - 11 years

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify N.D.(Signature) Eric E. Erickson, M. D.ERIC E. ERICKSON

(Print or Type Name)

(Address) LAHEY CLINIC Date 14 MAY 19 71

6 RURAL CEMETERY SOUTHBOROUGH  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 15, 1971

7 NAME OF FUNERAL DIRECTOR DONALD C. MORRIS  
40 MAIN ST. SOUTHBOROUGH MASS  
ADDRESS

Received and filed William J. Name MAY 19 1971

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED MARRIED  
WIDOWED MARRIED  
DIVORCED MARRIED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of CHARLES S. BARTON  
(Husband's name in full)

12 AGE 50 Years 3 Months 22 Days If under 24 hours  
Hours Minutes

13 Usual Occupation HOUSE WIFE  
(Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. ?

16 BIRTHPLACE (City) WORCESTER  
(State or country) MASS

17 NAME OF FATHER JAMES P. MCCONOLOGUE

18 BIRTHPLACE OF FATHER (City) DANVERS  
(State or country) MASS

19 MAIDEN NAME OF MOTHER HELEN FLOOD

20 BIRTHPLACE OF MOTHER (City) MILLBURY  
(State or country) MASS

21 Informant CHARLES S. BARTON  
116 MAIN ST. SOUTHBOROUGH MASS.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

PLACE OF DEATH

Worcester  
(County)  
Westborough  
(City or Town)COPY OF  
CERTIFICATE OF DEATH

Westborough (This return)

# 15

Registered No. ....

No. Westborough State Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME Helen Gertrude (Whatley) Angell

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Permanent Residence. No. 16 Boston Road St. Southborough, Mass.  
(City or town and State)

4 0 14

10 1 5

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 22, 1971  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased on  
May 8, 1971, to May 22, 1971I last saw him alive on May 22, 1971, death is said to  
have occurred on the date stated above, at 1:00a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia 24 hrs

(b) Due To Arteriosclerotic Heart Disease 10 yr

(c) Due To Gen. Arteriosclerosis 10 yr

OTHER SIGNIFICANT CONDITIONS Senile Dementia 10 yr

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Attending Physician) H.J.C. MacMillan, M.D.

Westboro  
(Address) State Hospital Date 5/22 19716 Central Cemetery Millbury,  
Place of Burial or Cremation (City or Town) Mass  
May 25, 1971

DATE OF BURIAL 1971

7 NAME OF FUNERAL DIRECTOR William A. Badger  
347 King St., Littleton, Mass

ADDRESS

Received and filed June 14, 1971

(Registrar of City or Town where deceased resided)  
Paul J. Berry

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED Married  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Charles Angell  
(Husband's name in full)12 AGE 80 Years 2 Months 7 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 011-18-5168B

16 BIRTHPLACE (City) Plainfield, Conn.  
(State or country)

17 NAME OF FATHER James Whatley

18 BIRTHPLACE OF FATHER (City) Trowbridge,  
(State or country) England

19 MAIDEN NAME OF MOTHER Mary Broadbent

20 BIRTHPLACE OF MOTHER (City) Lancashire,  
(State or country) England21 Informant Westborough State Hospital  
Records & Edgar C. Angell, son,  
(Address) P.O. Box 488, Geneva, N.Y., 14456

A TRUE COPY

ATTEST: Elizabeth M. Balow  
(Registrar of City or Town where death occurred)

DATE FILED May 26, 1971



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

1

PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. # 17

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Mary S. Maguire (Sheehan)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 9 Winchester St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 22 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Jan 1 1959 to May 22 1971  
I last saw her alive on April 11 1971, death is said to have occurred on the date stated above, at 1:20pm.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary thrombosis  
Due To  
(b) Arteriosclerotic heart disease  
Due To  
(c) none

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

5 dys.  
11 yrs.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no  
What test confirmed diagnosis? clinical course

5 Was disease or injury in any way related to occupation of deceased no  
If so, specify

Timothy P. Stone,  
(Attending Physician) M.D.

(Address) Southboro Date 5/23/71 19

6 Rural Cemetery, Southboro, Mass.  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL May 25 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Austin M. Maguire  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of John T. Maguire  
(Husband's name in full)

13 AGE 83 Years 4 Months 13 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business at home

16 Social Security No. none

17 BIRTHPLACE (City) Marlboro, Mass.  
(State or country)

18 NAME OF FATHER Michael Sheehan

19 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

20 MAIDEN NAME OF MOTHER Anna Sullivan

21 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED June 16 1971 19

Received and filed May 26, 1971  
June 16 1971  
(Registrar of City or Town where deceased resided)



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

Worcester

(County)

Clinton

(City or Town)

COPY OF  
 CERTIFICATE OF DEATH

Registered No. # 19

No. Lakeview Nursing Home

(If death occurred in a hospital or institution,  
 St. { give its NAME instead of street and number)

2 FULL NAME Addie L. (Hodge) Sanborn

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
 U. S. War Veteran,  
 if so specify WAR)

(a) Permanent Residence. No.

240 Parkerville Rd.

St. Southborough, Ma.

(City or town and State)

Length of stay: In place of death 4 years 6 months days. In place of residence 91 years 3 months 19 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 12, 1971  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

June 6, 1968, to June 12, 1971

I last saw him live on June 11, 1971 death is said to

have occurred on the date stated above, at 5:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral vascular thrombosis

Due To Atherosclerosis

Due To

(c)

OTHER  
 SIGNIFICANT  
 CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Richard A. Bartlett, M. D.

(Address) Clinton, Ma. Date 6/13 1971

6 Rural Cemetery, Southborough, Ma.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL June 14, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St., Southborough, Ma.

Received and filed June 30 1971

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)  
 MARRIED WIDOWED Divorced UNKNOWN11 If married, widowed, or divorced  
 HUSBAND of (Give maiden name of wife in full)(or) WIFE of Austin Sanborn  
 (Husband's name in full)12 AGE 95 Years 9 Months 19 Days If under 24 hours  
 Hours Minutes13 Usual Occupation: Housewife  
 (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. 022-09-6888

16 BIRTHPLACE (City) Southborough, Mass.  
 (State or country)

17 NAME OF FATHER Roswell Hodge

18 BIRTHPLACE OF FATHER (City) CNBL  
 (State or country) Vermont

19 MAIDEN NAME OF MOTHER CNBL

20 BIRTHPLACE OF MOTHER (City) CNBL  
 (State or country) Vermont

21 Informant Orman Sanborn

(Address) 240 Parkerville Rd., Southborough, Ma.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED June 14, 1971



for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
FILLING OUT  
THIS CERTIFICATE

FOR TYPE  
OR CAUSES  
OF DEATH

not enter  
more than one  
cause for each  
(b) and (c)

does not mean  
mode of dying,  
heart failure,  
etc. It means  
cause, or compli-  
cations which caused

conditions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

conditions contrib-  
uted to death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #18

PLACE OF DEATH

Worcester  
(County)Southborough  
(City or Town)

No. 36 East Main Street

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Philip W. Burke

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, if so specify WAR) None

(a) Permanent Residence. No. 36 East Main

Southborough Mass.

(City or town and State)

Length of stay: In place of death 51 years.....months.....days. In place of residence 51 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 18 1971  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Sept 12 1947 to June 18 1971I last saw him alive on June 18 1971, death is said to  
have occurred on the date stated above, at 9:06 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchogenic Carcinoma, Lung

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) Timothy P. Stone, M. D.

TIMOTHY P. STONE

(Print or Type Name)

(Address) 42 Main St., Southboro Date June 20 1971

6 Rural Cemetery Southborough, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 21 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street Southborough, Mass.  
ADDRESS

Received and filed June 21 1971

Paul J. Berry, Town Clerk

(Registrar)

A TRUE COPY ATTEST:

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

White

10 SINGLE (write the word)

MARRIED Married

WIDOWED

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Eleonora E. Pantony

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 56 Years 9 Months 2 Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation Traffic Manager

(Kind of work done during most of working life)

14 Industry

or Business Parker Mfg. Co.

15 Social Security No.

018-18-7518

16 BIRTHPLACE (City)

Marlboro

(State or country)

Mass.

17 NAME OF

FATHER

John H. Burke

18 BIRTHPLACE OF

FATHER (City)

Southborough

(State or country)

Mass.

19 MAIDEN NAME

OF MOTHER

Hazel F. Barney

20 BIRTHPLACE OF

MOTHER (City)

Southborough

(State or country)

Mass.

21 Informant Eleonora E. Burke

36 East Main St. Southborough, Mass.

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Sina A. Nicolai, Agent

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

PLACE OF DEATH

**Middlesex**  
(County)

**Framingham**  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. **# 20**

No. **Framingham Union Hospital**

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
**PHYSICIAN—IMPORTANT**

2 FULL NAME **Margaret M. Church (Kane)**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. **13 Reservoir Drive** St. **Southborough, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **June 21 1971**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **4-20**, 19**71**, to **6-21**, 19**71**.  
I last saw her alive on **7-20**, 19**71**. death is said to  
have occurred on the date stated above, at **2:50 a.m.**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Pulmonary Fibrosis**

Due To (b) **Chronic bronchitis**

Due To (c) **Asthma**

OTHER SIGNIFICANT CONDITIONS **Arteriosclerotic heart disease**

Was autopsy performed? **no**

What test confirmed diagnosis? **x-ray, ECG, Course, ec.**

5 Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify

**Timothy P. Stone**  
(Attending Physician) M.D.

(Address) **Southboro** Date **6-21 71**

6 **Mt. Calvary Cem., Buffalo, N.Y.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **June 24 1971**

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**  
ADDRESS **Southborough, Mass.**

8 Informant **Mrs. Margaret M. Eberl**  
(Address) **Southborough, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **Widowed**

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of **Arthur Church**  
(Husband's name in full)

13 AGE **73** Years **5** Months **24** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **Housewife**  
(Kind of work done during most of working life)

15 Industry or Business **At home**

16 Social Security No. **062-18-1496**

17 BIRTHPLACE (City) **Buffalo**  
(State or country) **New York**

18 NAME OF FATHER **Patrick Kane**

19 BIRTHPLACE OF FATHER (City) **Buffalo**  
(State or country) **N. Y.**

20 MAIDEN NAME OF MOTHER **Julia Healy**

21 BIRTHPLACE OF MOTHER (City) **Buffalo**  
(State or country) **N. Y.**

A TRUE COPY

ATTEST: **Richard J. Ward**  
(Registrar of City or Town where death occurred)

DATE FILED **6-21-71**

Received and filed **6-21-71** 19  
**July 19, 1971** **Paul J. Berry**  
(Registrar of City or Town where deceased resided)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

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## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

1 PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. # 21

No. Framingham Union Hospital St. {

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Theresa Agnes Morin (O'Donnell)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 26 East Main

St. Southborough, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 26 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Jan. 28 63, 1963, to June 26 71, 1971.  
I last saw him alive on June 26 71, 1971. death is said to  
have occurred on the date stated above, at 2:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pericarditis, uremic

Due To

(b) Nephrosclerosis (K.W.)

Due To

(c) Diabetes mellitus

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro Date 6-27-71

6 Rural Cemetery, Southborough  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 29 19 71

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southborough

8 Informant Joseph R. Morin  
(Address) Southborough

PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR W 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph R. Morin  
(Give husband's name in full)

13 AGE 37 Years 5 Months 25 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 028-26-9451

17 BIRTHPLACE (City) Northampton  
(State or country) Mass.

18 NAME OF FATHER Richard H. O'Donnell

19 BIRTHPLACE OF FATHER (City) Westminster  
(State or country) Vermont

20 MAIDEN NAME OF MOTHER Mary E. Delaney

21 BIRTHPLACE OF MOTHER (City) Southborough  
(State or country) Mass.

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED 6-29-71 19

Received and filed July 19, 1971 19  
Paul J. Berry  
(Registrar of City or Town where deceased resided)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. # 22

No. Framingham Union Hospital St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Bhatt Baby Boy  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 205 Cordaville Rd. St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from June 26 71 to June 28 71  
I last saw him alive on June 27 1971 death is said to  
have occurred on the date stated above, at 11:00 am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Birth wgt. & Gestation

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

P. J. Morganelli  
(Attending Physician) M.D.

(Address) Framingham Date 6-28-71

6 Edgell Grove Cem., Framingham  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 29 1971

7 NAME OF FUNERAL DIRECTOR Boyle Bros.

ADDRESS Framingham, Mass.

8 Informant Satish Bhatt  
(Address) Southboro, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR Colored 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Infant

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE Years Months 2 Days If under 24 hours  
Hours Minutes

14 Usual Occupation (Kind of work done during most of working life)

15 Industry or Business

16 Social Security No.

17 BIRTHPLACE (City) Framingham  
(State or country) Mass.

18 NAME OF FATHER Satish Bhatt

19 BIRTHPLACE OF FATHER (City) India  
(State or country)

20 MAIDEN NAME OF MOTHER Kalpane Bhatt

21 BIRTHPLACE OF MOTHER (City) India  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 6-29-71 1971

Received and filed July 19, 1971

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. # 24

PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



No. Framingham Union Hospital St. {

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Walter Barnard Brewer  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) No

(a) Permanent Residence, No. 211 Boston Rd.

St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 9, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Sept. 7, 1948 to July 9, 1971.  
I last saw him alive on July 9, 1971 death is said to have occurred on the date stated above, at 11:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolism

Due To (b) Phlebothrombosis, calves

Due To (c) Pulmonary emboli  
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 7/10 1971

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12, 1971

7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell  
ADDRESS Marlboro, Mass.

8 Informant Mrs. Charlotte Brewer  
(Address) Southboro, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) Married  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced HUSBAND of Charlotte Robins  
(or) WIFE of (Husband's name in full)

13 AGE 80 Years 0 Months 11 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Farming & market gardener

15 Industry or Business

16 Social Security No. 011-28-2801

17 BIRTHPLACE (City) Southboro,  
(State or country) Mass.

18 NAME OF FATHER Nahum Brewer

19 BIRTHPLACE OF FATHER (City) CNBL  
(State or country)

20 MAIDEN NAME OF MOTHER Mary Barnard

21 BIRTHPLACE OF MOTHER (City) CNBL,  
(State or country)

A TRUE COPY

ATTEST: Richard J. Wood  
(Registrar of City or Town where death occurred)

DATE FILED July 13, 1971

Received and filed July 19, 1971  
Paul J. Berry  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. # 23

No. Meadowbrook Manor Lodge St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Hazel Holmes (Rowell) { (If deceased a U. S. War Veteran, specify WAR) None  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. Parkerville Rd. St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 9, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Nov. 15, 1948 to July 9, 1971  
I last saw him alive on July 9, 1971 death is said to have occurred on the date stated above, at 9:00P.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Diabetes mellitus

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Hypertension

Was autopsy performed? No

What test confirmed diagnosis? Clinical course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

Timothy P. Stone,  
(Attending Physician) M.D.

(Address) Southboro, Mass. 7/9 1971

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 12, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Mrs. Charlotte Dyer  
(Address) 17 N. Main St., Waterbury, Vt.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) Widowed  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles H. Holmes

13 AGE 76 years 10 months 9 days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife & merchant  
(Kind of work done during most of working life)

15 Industry or Business Variety store

16 Social Security No. 021-28-7946

17 BIRTHPLACE (City) St. Albans, Vt.  
(State or country)

18 NAME OF FATHER Edward E. Rowell

19 BIRTHPLACE OF FATHER (City) St. Albans, Vt.  
(State or country)

20 MAIDEN NAME OF MOTHER Inez Thompson

21 BIRTHPLACE OF MOTHER (City) Greensboro, Vt.  
(State or country)

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED July 13, 1971

Received and filed July 19, 1971

Paul J. Berry  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



filed for burial permit  
th Board of Health  
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-70-047760

1

PLACE OF DEATH

Worcester

(County)

Southborough

(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

# 25

No.

St.

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME

Frederick M.

Butler

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

(if so specify WAR)

X X

(a) Permanent Residence. No. 2804 Stearns Hill Rd. Waltham Mass.

(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 21 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease,  
presumably coronary occlusion  
(Sudden) death on golf  
course

5 Accident, suicide, or homicide (specify)

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? ..... While at work? .....

(How did injury occur?)

Manner of

Injury

(Specify type of place)

Nature of

Injury

Was autopsy performed? No

Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) S. Alden Guild M.D.

(Address) 50 Main St. Waltham

Date July 22 1971

6 North Cemetery Wayland  
Place of Burial or Cremation (City or Town)

DATE July 24 1971

7 NAME OF FUNERAL DIRECTOR J.S. Waterman Sons

ADDRESS 419 S. Commonwealth Ave. Boston

8 Informant Eleanor J. Butler

(Address) 2804 Stearns Hill Rd. Waltham

PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

Male White Married

12 If married, widowed, or divorced Eleanor Lorio

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 65 YEARS 4 MONTHS 16 Days If under 24 hours  
Hours Minutes

14 Usual Occupation Executive  
(Kind of work done during most of working life)

15 Industry or Business Liberty Mutual Ins. Co.

16 Social Security No. 252-10-6799

17 BIRTHPLACE (City) Middleboro

(State or country) Mass

18 NAME OF FATHER Frederick John Butler

19 BIRTHPLACE OF FATHER (City) Yarmouth

(State or country) Nova Scotia

20 MAIDEN NAME OF MOTHER Submittanne Burkholder

21 BIRTHPLACE OF MOTHER (City) Yarmouth

(State or country) Nova Scotia

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Sina A. Torcolato - Agent  
(Signature of Agent Board of Health or other)

(Official Designation) 7-22-71  
(Date of Issue of Permit)

Received and filed July 23, 1971

Paul J. Berry (Registrar)

A TRUE COPY ATTEST:



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

20M-9-70-047762

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Framingham

(City or Town making this return)

# 26

Registered No. ....

No. .... Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry A. Costello  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Permanent Residence. No. 151 Marlboro Rd., St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Brain injury  
Intracranial hemorrhage and  
subdural hemorrhage5 Accident, suicide, or homicide (specify) Accident  
Date and hour of injury 4 am 7/21 71

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur? Westboro, Mass.  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? East Main St. no  
(How did injury occur?) While at work?Manner of injury Fell in grease pit  
(Specify type of place)

Nature of injury see above

Was autopsy performed? no

Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham Date 8/1/71  
(Print or Type Name)6 Rural Crematory, Worcester  
Place of Burial or Cremation (City or Town)

DATE August 3, 1971

7 NAME OF FUNERAL DIRECTOR Richard Coldwell  
ADDRESS Marlboro, Mass.8 Informant Mr. Harry A. Costello  
(Address) 64 Water St., Marlboro

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN  
(write the word) widowed12 If married, widowed, or divorced HUSBAND of Dorothy Lloyd  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 55 YEARS 7 MONTHS 3 Days If under 24 hours  
.....Hours .....Minutes14 Usual Occupation: Painter  
(Kind of work done during most of working life)

15 Industry or Business: none

16 Social Security No. 027 10 0632

17 BIRTHPLACE (City) Worcester, Mass.  
(State or country)

18 NAME OF FATHER Thomas F. Costello

19 BIRTHPLACE OF FATHER (City) Boston, Mass.  
(State or country)

20 MAIDEN NAME OF MOTHER Rose Armetage

21 BIRTHPLACE OF MOTHER (City) England  
(State or country)A TRUE COPY  
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 71 August 20 1971

Received and filed August 20 1971  
Paul J. Berry August 4, 71  
(Registrar of City or Town where deceased resided)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. **#27**

No. **Framingham Union Hospital** St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME **Thelma E. Craig (Mathewson)** { (If deceased a  
(If deceased is a married, widowed or divorced woman, give also maiden name.) U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. **20 Latisquama Rd.,** St. **Southborough, Mass.**

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 28, 1971**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **Aug 23**, 19**71**, to **Aug 28**, 19**71**.  
I last saw him alive on **Aug 28**, 19**71**, death is said to have occurred on the date stated above, at **10am**.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Pulmonary embolism**  
(b) **1 hrs.**  
(c) **10+ yrs.**

OTHER SIGNIFICANT CONDITIONS **Parkinsonism**  
**parietal lobe infarction 2 wks plus**

Was autopsy performed? **no**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Attending Physician) **William Wiener,** M.D.

(Address) **Framingham** Date **8/30/71**

6 **Maplewood Cem., Marlboro, Mass.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 31, 1971**

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**  
ADDRESS **Southboro, Mass.**

8 Informant **Karl S. Craig**  
(Address) **Southborough, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **female** 10 COLOR **white** 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN **married**

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **Karl S. Craig** (Give husband's name in full)

13 AGE **61** Years **5** Months **22** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **Housewife**  
(Kind of work done during most of working life)

15 Industry or Business **at home**

16 Social Security No. **none**

BIRTHPLACE (City) **Marlboro, Mass.**  
(State or country)

18 NAME OF FATHER **Alexander Mathewson**

19 BIRTHPLACE OF FATHER (City) **Canada**  
(State or country)

20 MAIDEN NAME OF MOTHER **Emma Moody**

21 BIRTHPLACE OF MOTHER (City) **Holliston, Mass.**  
(State or country)

A TRUE COPY **Richard J. Ward**

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED **19**

Received and filed **Sept. 8, 1971 (August 31, 1971)**  
**Paul J. Berry**  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



filed for burial permit  
th Board of Health  
or its Agent.

NOTE: CHAP. 107, ROLE OF 1907, REQUIRES THE FILING OF ALL  
OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of  
information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF  
DEATH in plain terms, so that it may be properly classified under the International Classification of Causes  
of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114,  
§§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SOM-9-70-047760

PLACE OF DEATH

Worcester

(County)

Southborough

(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

#28

No. 160 Southville Road

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME

Josephine M.

(First Name)

(Middle Name)

O'Donnell

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran, None

(If so specify WAR)

(a) Permanent Residence. No. 160 Southville Road

St. Southborough, Mass.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH

Sept. 1

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease,  
presumably coronary throm-  
bosis (Sudden Death)

5 Accident, suicide, or homicide (specify)

Date and hour of injury

19

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? While at work?

(How did injury occur?)

Manner of

Injury

(Specify type of place)

Nature of

Injury

Was autopsy performed? NO

Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)

S. Alden Gould

M. D.

S. Alden Gould M.D.

(Print or Type Name)

(Address)

Stetson

Date

9-1-

1971

6 St. Lukes Cemetery Westboro, Mass.

Place of Burial or Cremation

(City or Town)

DATE Sept. 4

1971

7 NAME OF

FUNERAL DIRECTOR Donald C. Morris

40 Main Street

ADDRESS

Southborough, Mass.

8 Informant

Mrs. Charles McNeil

(Address)

160 Southville Road, Southborough

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

F

10 COLOR

White

11 SINGLE

(write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 77 YEARS 5 MONTHS 1 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Retired

(Kind of work done during most of working life)

15 Industry

or Business:

at Home

16 Social Security No. 022-07-5647

17 BIRTHPLACE (City)

Southborough

(State or country)

Mass.

18 NAME OF

FATHER

William O'Donnell

19 BIRTHPLACE OF

FATHER (City)

County Tipperary

(State or country)

Ireland

20 MAIDEN NAME

OF MOTHER

Margaret Halley

21 BIRTHPLACE OF

MOTHER (City)

County Tipperary

(State or country)

Ireland

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Orscolelli, Agt

(Signature of Agent Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

Received and filed September 8, 1971

1 and 1 Berry

(Registrar)

TRUE COPY ATTEST:



2009

M R-303

and for burial permit  
Board of Health  
its Agent.

N. B. - WRITE PLAINLY, WITH UNFADING BLACK INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100N-9-63-936348

PLACE OF DEATH

Worcester  
(County)

Worcester  
(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER  
(City or Town making this return)

Registered No. **2105**  
# 30

No. **St. Vincent Hospital**

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME **Kenneth J. Trogolo**

(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. **6 Tara Road**  
(Usual place of abode)

St. **Southborough, Mass.**  
(If nonresident, give city or town and State)

Length of stay: In place of death. years months **2** days. In place of residence. years **1** months **6** days **21** days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Sept. 1 1971**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

**crushing injuries into abdomen**

5 Accident, suicide, or homicide (specify) **accident**

Date and hour of injury **1 pm Aug 31 1971**

IF ACCIDENTAL, was injury causally related to the death? **yes**

Where did injury occur? **Southboro, Mass.**  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? **driver on Tara Rd**  
(Specify type of place)

Manner of injury **truck auto backing out**  
(How did injury occur?)

Nature of injury **head injury - fractured skull**  
While at work? **no** Was autopsy performed? **YES**

6 Was disease or injury in any way related to occupation of deceased? **no**

If so, specify

(Signed) **John A. Trogolo**, M. D.

(Print or Type Name)

(Address) **978 Main St** Date **Sept 2 71**

7 **Rural cemetery Southborough, Mass.**  
Place of Burial or Cremation, (City or Town)

DATE OF BURIAL **Sept. 4 1971**

8 NAME OF FUNERAL DIRECTOR **Donald C. Morris**

ADDRESS **40 Main St. Southborough, Mass.**

Received and filed **SEP 3 1971**

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **M** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED** **Single**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

12 If married, widowed, or divorced  
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE **1** Years **6** Months **21** Days If under 24 hours  
Hours Minutes

14 Usual Occupation: **Baby**  
(Kind of work done during most of working life)

15 Industry or Business: **at home**

16 Social Security No. **None**

17 BIRTHPLACE (City) **Worcester**  
(State or country) **Mass.**

18 NAME OF FATHER **John A. Trogolo**

19 BIRTHPLACE OF FATHER (City) **Springfield**  
(State or country) **Ill.**

20 MAIDEN NAME OF MOTHER **Louise Coward**

21 BIRTHPLACE OF MOTHER (City) **Philadelphia**  
(State or country) **Penna.**

22 Informant **John A. Trogolo**  
(Address)

**6 Tara Road, Southborough, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or cremation permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation of Commissioner of Public Health or Title of Permit)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham

(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #31

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

Robert W. Sealey

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

25 White Bagley Rd.,

Southborough

(a) Permanent Residence, No. St. (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 3, 1971  
(Month) (Day) (Year)4 I HEREBY CERTIFY that I attended deceased from Sept 22 to Oct 3, 1971  
I last saw him alive on October 3, 1971, death is said to have occurred on the date stated above, at 8pm.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia  
(b) Septicemia (staph)  
(c) Peritoneal abscess sac lesserOTHER SIGNIFICANT CONDITIONS  
Meningitis, endocarditis, mesenteric thrombosisWas autopsy performed? yes  
What test confirmed diagnosis? autopsy5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

Timothy P. Stone,

(Attending Physician) M.D.

(Address) Southboro, Mass 10/5/71 Date 1971

6 Rural Cem., Southborough, Mass.

Place of Burial or Cremation (City or Town)  
DATE OF BURIAL October 7, 19717 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southborough, Mass.8 Informant Mrs. Nancy B. Burnham  
(Address) 279 Riverneck Rd., Chelmsford

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed or divorced HUSBAND of Lucy Bowen (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 63 years 1 Months 10 Days If under 24 hours Hours Minutes

14 Usual Occupation Teamster (Kind of work done during most of working life)

15 Industry or Business self employed

16 Social Security No. 032 03 7780

17 BIRTHPLACE (City) Southborough, Mass. (State or country)

18 NAME OF FATHER John C. Sealey

19 BIRTHPLACE OF FATHER (City) Southborough, Mass. (State or country)

20 MAIDEN NAME OF MOTHER Deborah B. Pratt

21 BIRTHPLACE OF MOTHER (City) Northboro, Mass. (State or country)

A TRUE COPY

ATTEST: Michael J. Ward (Registrar of City or Town where death occurred)

DATE FILED October 14, 1971

Received and filed November 17, 1971

Paul Berry (Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

20M1-9-70-047762

1

PLACE OF DEATH

Middlesex

(County)

Marlborough

(City or Town)

The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

Registered No. 279

#29

No. Rt. 85 Marlboro, Mass.

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Norma (Wentzell) (Shirra) Benkoski

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

[if so specify WAR] no

(a) Permanent Residence. No. 116 Marlboro Road Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9, 1971

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Head and neck injuries -  
due to auto accident5 Accident, suicide, or homicide (specify) accident  
Date and hour of injury 4:15pm. Oct. 9, 1971

IF ACCIDENTAL, was injury causally related to the death? yes

Where did

Injury occur?

Marlborough, Mass.

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? no

Manner of

Injury

thrown from car in collision with utility pole

(Specify type of place)

Nature of

Injury

injuries to head and neck

Was autopsy performed? no

Was disease or injury in any way related to occupation of deceased? no

If so, specify

R. N. Rittenhouse

(Signed)

M. D.

(Address) Marlboro, Mass. Oct. 9, 1971

6 Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation

(City or Town)

DATE October 13, 1971

7 NAME OF FUNERAL DIRECTOR Boyle Bros.

ADDRESS 178 Union Ave. Framingham, Mass.

8 Informant Mr. Victor M. Benkoski - husband

(Address) 16 Marlboro Rd. Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

Female

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Victor M. Benkoski

(Husband's name in full)

13 AGE 39 YEARS - MONTHS - Days

If under 24 hours

Hours Minutes

14 Usual

Occupation: at home

(Kind of work done during most of working life)

15 Industry

or Business:

at home

16 Social Security No. 017 - 24 - 2878

17 BIRTHPLACE (City)

(State or country)

Brookline, Mass.

18 NAME OF

FATHER

David Wentzell

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Nova Scotia

20 MAIDEN NAME

OF MOTHER

Gertrude Bouley

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

cannot be learned

A TRUE COPY

ATTEST:

Peter P. Lapine  
Peter P. Lapine

(City or Town where death occurred)

DATE Agent Oct. 12, 1971

Received and filed October 16, 1971

(Registrar of City or Town where deceased resided)



13/91  
RM R-301

led for burial permit  
Board of Health  
or its Agent.

RUCTIONS FOR  
AL CERTIFICATE

INT OR TYPE  
SE OR CAUSES  
OF DEATH  
UNFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
: It means the disease, or  
ations which caused death.

itions, if any, which gave  
above cause (a), stating the  
ing cause last.

itions contributing to death  
related to the terminal dis-  
dition given in (a).

531.1

PLACE OF DEATH

OUT-OF-TOWN

Suffolk  
(County)

Boston  
(City or Town)



The Commonwealth of Massachusetts

BOSTON

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)  
#34

STANDARD  
CERTIFICATE OF DEATH

Registered No. 8657

No. New England Deaconess Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Mr. Alfred W. Howes (If deceased is a married, widowed or divorced woman, give also maiden name.) (If deceased a U. S. War Veteran, specify WAR) WWI

(a) Permanent Residence. No. 10 Main St. Southboro, Mass. (City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 9, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from September 19, 1971, to October 9, 1971. I last saw him alive on October 9, 1971, death is said to have occurred on the date stated above, at 9:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Perforated Gastric Ulcer

Due To (b) with Peritonitis, Gram

Due To (c) negative sepsis

OTHER SIGNIFICANT CONDITIONS Lymphosarcoma

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Peter Codruchi M.D.  
(Print or Type Name) Peter Codruchi  
(Address) 200 Main St. Southboro, Mass. Date 10 Oct 71

6 RURAL CEMETERY SOUTHBOROUGH MASS  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT 13 1971

7 NAME OF FUNERAL DIRECTOR DONALD C MORRIS  
ADDRESS 10 MAIN ST. SOUTHBOROUGH, MASS

8 Informant MRS ALFRED W. HOWES  
(Address) 10 MAIN ST. SOUTHBOROUGH MASS

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR WHITE 11 SINGLE (write the word) MARRIED  
MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of CATHERINE LOW (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 72 Years 0 Months 5 Days | If under 24 hours Hours Minutes

14 Usual Occupation LAWYER (Kind of work done during most of working life)

15 Industry or Business LAW

16 Social Security No. 013-32-7702

17 BIRTHPLACE (City) SOUTHBOROUGH (State or country) MASS

18 NAME OF FATHER SETH. H. HOWES.

19 BIRTHPLACE OF FATHER (City) CHATHAM (State or country) MASS

20 MAIDEN NAME OF MOTHER CATHERINE LAVELLE

21 BIRTHPLACE OF MOTHER (City) SOUTHBOROUGH (State or country) MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph A. Connor (Signature of Agent Board of Health or other)

J 04937 (Official Designation)

October 10, 1971 (Date of Issue of Permit)

Received and filed OCT 14 1971 19

A TRUE COPY ATTEST: (Registrar)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #32

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Katherine E. Fitzgerald  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)  
(a) Permanent Residence, No. 268 Cordaville Rd. St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 12 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
8-26 1971 to 10-12 1971  
I last saw him alive on 10-11 1971. Death is said to  
have occurred on the date stated above, at 2:30 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized metastatic  
carcinoma  
(b) Ca of breast  
(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1yr.  
3yrs.

OTHER  
SIGNIFICANT  
CONDITIONS

Terminal stress ulcer 24hrs

Was autopsy performed? no

What test confirmed diagnosis? Surgical biopsy

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Attending Physician) Charles J. Morgan, M.D.

(Address) Ashland Date 10-15 1971

6 St. Johns Cem., Hopkinton  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 16 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Mary Fitzgerald  
(Address) Southborough

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR W 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 79 years 11 Months 28 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Executive Secretary  
(Kind of work done during most of working life)

15 Industry or Business Law firms

16 Social Security No. 019-10-4414

17 BIRTHPLACE (City) Hopkinton  
(State or country) Mass.

18 NAME OF FATHER Thomas F. Fitzgerald

19 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

20 MAIDEN NAME OF MOTHER Margaret J. Haley

21 BIRTHPLACE OF MOTHER (City) Hopkinton  
(State or country) Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 10-18-71 19

Received and filed November 17, 1971

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

20M-9-70-047762

PLACE OF DEATH

Middlesex  
(County)Marlborough  
(City or Town)The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

Registered No. 303

#33

No. Marlboro Hospital D.O.A. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Natalie G. Cooper

(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. 9 School St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 1, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebral vascular accident  
sudden death

5 Accident, suicide, or homicide (specify) none

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? While at work? (How did injury occur?)

Manner of Injury (Specify type of place)

Nature of Injury

Was autopsy performed? no

Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) R. N. Rittenhouse, M. D.

(Print or Type Name)  
(Address) Marlboro, Mass. Nov. 1, 1971

6 Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE November 4, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

8 Informant Laurence A. Cooper, Jr.

(Address) 301 St. Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Laurence A. Cooper, Jr.

(or) WIFE of (Husband's name in full)

13 AGE 47 YEARS 9 MONTHS 17 Days If under 24 hours Hours Minutes

14 Usual Occupation: Realtor (Kind of work done during most of working life)

15 Industry or Business: Real Estate

16 Social Security No. 316 20 6643

17 BIRTHPLACE (City) Benton Harbor, Michigan (State or country)

18 NAME OF FATHER Nathaniel Green

19 BIRTHPLACE OF FATHER (City) Brooklyn, New York (State or country)

20 MAIDEN NAME OF MOTHER Margaret Jeffrey

21 BIRTHPLACE OF MOTHER (City) Chicago, Illinois (State or country)

A TRUE COPY ATTEST [Signature] (Register of City or Town where death occurred)

DATE FILED Agent November 3, 1971

Received and filed November 3, 1971 (Registrar of City or Town where deceased resided) 11/24/71



JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSWestborough  
(City or Town making this return)COPY OF  
CERTIFICATE OF DEATH

Registered No. #37

No. Westborough State Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)2 FULL NAME Olga (Sara) Tombari  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 16 Cherry St. Southborough, Mass. (City or Town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 11, 1971  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from  
Nov. 10, 71 to Nov. 11, 71I last saw him alive on Nov. 11, 71, death is said to  
have occurred on the date stated above, at 9:30A.M.DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Broncho-Pneumonia

(a) 1 wk

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) M. D.

Jacob K. Rosemark, M.D.

(Address) Westboro State Hospital Date 11/11 71

6 St. Michael's Cem., Springfield, Mass  
Place of Burial or Cremation (City or Town and State)

DATE OF BURIAL November 15, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
40 Main St., Southborough, Mass

ADDRESS

Received and filed December 13, 1971

Paul J. Berry, Town BEAR  
(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married11 If married, widowed, or divorced  
HUSBAND of Frederico Tombari  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation: Unemployed  
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. C.N.B.L.

16 BIRTHPLACE (City) Italy  
(State or country)

17 NAME OF FATHER Eugene Sara

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER C.N.B.L.

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)21 Informant Frederico Tombari  
16 Cherry St., Southborough  
(Address) & Westborough State Hospital  
Medical Records

A TRUE COPY

ATTEST: Elizabeth M. Balow  
(Registrar of City or Town where death occurred)

DATE FILED November 18, 1971

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORDCopies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town  
at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased  
resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Marlborough  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 320

# 36

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Hector A. Bonenfant  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) W.W. I

(a) Permanent Residence, No. 22 Meadow Lane St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 26, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Nov. 25, 1971, to Nov. 26, 1971.  
I last saw him alive on Nov. 25, 1971.  
Death is said to have occurred on the date stated above, at 1:30a.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

E. Abramson  
(Attending Physician) M.D.

(Address) Marlboro Mass. Nov. 26, 1971

6 St. Mary's Cem. Marlboro, Mass.  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL Nov. 29, 1971

7 NAME OF FUNERAL DIRECTOR Roland Dessein  
ADDRESS 451 Lincoln St. Marlboro, Mass.

8 Informant Mrs. Antoinette Bonenfant  
(Address) 22 Meadow Lane, Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of Antoinette Danjou  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 78 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation Laborer  
(Kind of work done during most of working life)

15 Industry or Business Metropolitan Water Comm.

16 Social Security No. 017 05 7475

17 BIRTHPLACE (City) (State or country) Suncook, New Hampshire

18 NAME OF FATHER Joseph Bonenfant

19 BIRTHPLACE OF FATHER (City) (State or country) Allenstown, New Hampshire

20 MAIDEN NAME OF MOTHER Victorine Brouseau

21 BIRTHPLACE OF MOTHER (City) (State or country) Province of Quebec

A TRUE COPY

ATTEST: Peter P. Cottone  
(Registrar of City or Town where death occurred)

DATE FILED Agent Nov. 27, 1971

Received and filed December 10, 1971

Paul J. Berry Town Clerk  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... May 16, 1918 .....

DATE OF DISCHARGE ..... March 21, 1919 .....

RANK, RATING ..... Private .....

Co. A, 2nd Engr. Jr. Regt.

ORGANIZATION AND OUTFIT ..... 2794279 .....

SERVICE NUMBER .....



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Northborough  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

#35  
Registered No. 70

No. Thornton Nursing Home St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Ida M. (Liberty) Hunt { (If deceased a  
(If deceased is a married, widowed or divorced woman, give also maiden name.) U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 45 Highland St. St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 27, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Oct. 30, 1964, to Nov. 27, 1971.  
I last saw her alive on Nov. 19, 1971, death is said to  
have occurred on the date stated above, at 10:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Acute myocardial infarction

(a) Due To Coronary sclerosis months

(b) Generalized Arteriosclerosis Yrs.

OTHER SIGNIFICANT CONDITIONS Chronic nephritis Yrs.  
Senility

Was autopsy performed? No

What test confirmed diagnosis? Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) James G. Boyd, M.D.  
52 W. Main St.

(Address) Westborough, Mass. Date Nov. 27, 1971

6 Rural Cemetery, Southborough, Ma.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 30, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St., Southborough, Ma.

8 Informant Richard O. Hunt

(Address) 192 Woodland Rd., Southborough, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED Divorced  
DIVORCED UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Howard Hunt (Husband's name in full)

13 AGE 86 Years 4 Months 16 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At Home

16 Social Security No. 028-16-4322

17 BIRTHPLACE (City) Southborough  
(State or country) Mass.

18 NAME OF FATHER Frank Liberty

19 BIRTHPLACE OF FATHER (City) Actonvale  
(State or country) P.Q. Canada

20 MAIDEN NAME OF MOTHER Mary Laviölette

21 BIRTHPLACE OF MOTHER (City) Actonvale  
(State or country) P.Q., Canada

A TRUE COPY  
ATTEST: Marion B. Flynn  
(Registrar of City or Town where death occurred)

DATE FILED Nov. 29, 1971

Received and filed December 8, 1971

(Registrar of City or Town where deceased resided) Town Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



PLACE OF DEATH

Middlesex  
(County)  
Framingham  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Framingham  
(City or Town making this return)

Registered No. #38

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Cheryl A. Drake  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Permanent Residence. No. 55 Southville Rd. St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 1, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Ruptured liver with massive  
intra-abdominal injuries  
Broken neck

5 Accident, suicide, or homicide (specify) Accident  
Date and hour of injury 3:50am 12/1 1971

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did injury occur? Framingham, Mass.  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Pleasant St. While at work? No  
(How did injury occur?)

Manner of injury CAR hit pole  
(Specify type of place)

Nature of injury See above

Was autopsy performed? Yes

Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham, Mass. Date 12/1 1971

6 Pine Grove Cem., Westboro, Mass.

Place of Burial or Cremation (City or Town)

DATE Dec. 3, 1971

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

8 Informant Albert H. Drake

(Address) 55 Southville Rd. Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 21 YEARS 9 MONTHS 11 Days If under 24 hours Hours Minutes

14 Usual Occupation: Lab. tech.  
(Kind of work done during most of working life)

15 Industry or Business: Animal hospital

16 Social Security No. 029-40-9029

17 BIRTHPLACE (City) Marlboro, Mass.  
(State or country)

18 NAME OF FATHER Albert H. Drake

19 BIRTHPLACE OF FATHER (City) Stoughton, Mass.  
(State or country)

20 MAIDEN NAME OF MOTHER Anna Schwenk

21 BIRTHPLACE OF MOTHER (City) Islin, Pa.  
(State or country)

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED Dec. 2, 1971

Received and filed January 7, 1972

(Registrar of City or Town where death occurred)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH Registered No. #39

No. KathleenDaniel Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Nina M. Hyde (Bruce) (If deceased is a married, widowed or divorced woman, give also maiden name.) (If deceased a U. S. War Veteran, specify WAR) no

(a) Permanent Residence. No. 1 Prentiss St. Southboro, Mass. (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10, 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from May 22, 1971 to Dec. 10, 1971.  
I last saw him alive on Dec. 8, 1971, death is said to have occurred on the date stated above, at 8:55 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Leukemia

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Marrow biopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 12/13, 1971

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 13, 1971

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Mrs. Eleanor Burke  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Frank L. Hyde (Husband's name in full)

13 AGE 89 Years 7 Months 0 Days | If under 24 hours Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 012-07-4293D

17 BIRTHPLACE (City) (State or country) Hopkinton, Mass.

18 NAME OF FATHER Ansel Bruce

19 BIRTHPLACE OF FATHER (City) (State or country) Hopkinton, Mass.

20 MAIDEN NAME OF MOTHER Etta J. Hutchings

21 BIRTHPLACE OF MOTHER (City) (State or country) Milford, Mass.

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED Dec. 14, 1971

Received and filed January 7, 1972

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #40

No. **Framingham Union Hospital** St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME **Frank Carter** { (If deceased a  
(If deceased is a married, widowed or divorced woman, give also maiden name.) U. S. War Veteran,  
specify WAR)

(a) Permanent Residence. No. **28 Turnpike Rd.** St. **Southboro, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 16 1971**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
**July 70** to **Dec. 71**  
I last saw him on **Dec. 15**, 19**71** death is said to  
have occurred on the date stated above, at **3**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Pneumonia**

Due To (b) **Leucopenia**

Due To (c) **Leukemia**

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **no**

What test confirmed diagnosis? **Lab study**

5 Was disease or injury in any way related to occupation of deceased? **no**

If so, specify

**Frank V. Coco**  
(Attending Physician) M.D.

(Address) **Framingham** Date **12-16** 19**71**

6 **Evergreen Cem., Marlboro**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 18** 19**71**

7 NAME OF FUNERAL DIRECTOR **John J. Brown, Sr.**  
ADDRESS **Marlboro**

8 Informant **Mrs. Eleanor Carter**  
(Address) **Southboro, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **M** 10 COLOR **W** 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN **Married**

12 If married, widowed, or divorced  
HUSBAND of **Eleanor Jaworek**  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE **66** years **8** Months **10** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **MDC Water Div.**  
(Kind of work done during most of working life)

15 Industry or Business **Comm of Mass.**

16 Social Security No. **032-05-2430**

17 BIRTHPLACE (City) **Haverhill**  
(State or country) **Mass.**

18 NAME OF FATHER **Frank M. Carter**

19 BIRTHPLACE OF FATHER (City) **Poland**  
(State or country)

20 MAIDEN NAME OF MOTHER **Vida CNBL**

21 BIRTHPLACE OF MOTHER (City) **Poland**  
(State or country)

A TRUE COPY

ATTEST: **Michael J. Ward**  
(Registrar of City or Town where death occurred)

DATE FILED **12-20-71** 19**71**

Received and filed **January 7, 72**  
**Paul J. Berry**  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Southborough Reg. #43

Registered No. 10975

New England Baptist Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

## PHYSICIAN - IMPORTANT

2 FULL NAME Gerard A. Galligan  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WWII

(a) Permanent Residence. No. 66 Main St. Southborough, Mass.  
(City or Town and State)

Length of stay: In place of death, years 3 months 3 days. In place of residence, years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 20 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1971, to Dec 20, 1971.

1 last saw him alive on December 20, 1971, death is said to have occurred on the date stated above, at 5:30 am.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) RENAL FAILURE

(b) Due To GRAM NEGATIVE SEPTICEMIA

(c) Due To PERITONITIS

OTHER SIGNIFICANT CONDITIONS CA PROSTATE RADICAL ENTEROCOLITIS PERITONITIS } YEARS

Was autopsy performed? ☒   
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No   
If so, specify NO(Signature) Elliot Prager, M. D.  
(Print or Type Name)

(Address) LAHEY CLINIC Date 12-20-1971

6 ST PETERS SARATOGA SPRINGS, NY  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 23 1971

7 NAME OF FUNERAL DIRECTOR DONALD C MORRIS  
40 MAIN ST SOUTHBOROUGH MASS  
ADDRESSReceived and filed DEC 23 1971  
William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR WHITE 10 SINGLE (write the word) MARRIED MARRIED  
WIDOWED UNKNOWN11 If married, widowed, or divorced HUSBAND of JOSEPHINE GRAY  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 55 Years 1 Months 14 Days If under 24 hours  
Hours Minutes13 Usual Occupation TEACHER  
(Kind of work done during most of working life)

14 Industry or Business HIGH SCHOOL LANGUAGES

15 Social Security No.

16 BIRTHPLACE (City) SARATOGA SPRINGS  
(State or country) NY

17 NAME OF FATHER JOHN J GALLIGAN

18 BIRTHPLACE OF FATHER (City) SARATOGA SPRINGS  
(State or country) NY

19 MAIDEN NAME OF MOTHER LOUIS DENNIN

20 BIRTHPLACE OF MOTHER (City) SARATOGA SPRINGS  
(State or country) NY

MRS GERARD A. GALLIGAN

21 Informant 66 MAIN ST SOUTHBOROUGH MASS  
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued  
Joanne Dennin, Head  
(Signature of Agent of Board of Health or other)DEC 20 1971  
(Date of Issue of Permit)

A TRUE COPY ATTEST:



The Commonwealth of Massachusetts  
 JOHN F. X. DAVOREN  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS  
 COPY OF  
 MEDICAL EXAMINER'S  
 CERTIFICATE OF DEATH

Framingham

Registered No. #41

PLACE OF DEATH

Middlesex

Framingham

No. Framingham Union Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Edna M. Perkins (Berry)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

No

(a) Permanent Residence. No.

84 Oak Hill Rd.

St.

Southboro, Mass.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

December 28, 1971

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Intra-abdominal hemorrhage  
 Secondary to ruptured spleen and  
 fractured skull  
 Accidental

5 Accident, suicide, or homicide (specify)

Accidental

Date and hour of injury

8:23pm 12/27 1971

IF ACCIDENTAL, was injury causally related to the death?

Yes

Where did injury occur?

Sudbury, Mass.

Did injury occur in or about home, on farm, in industrial place, or in public place?

Car hit pole While at work? No

Manner of injury

Car hit telephone pole

Nature of injury

See above

Was autopsy performed?

Yes

Was disease or injury in any way related to occupation of deceased?

No

If so, specify

(Signed)

Luke G. Tedeschi

M. D.

(Address)

Framingham, Mass. 12/28 1971

6

Wyoming Cem., Melrose, Mass.

Place of Burial or Cremation

(City or Town)

DATE

Dec. 31, 1971

7 NAME OF FUNERAL DIRECTOR

Donald C. Morris

ADDRESS

Southboro, Mass.

8 Informant

Frank J. Perkins

(Address)

Nabnasset, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Widowed

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

George F. Perkins

13 AGE

YEARS

1

MONTHS

27

Days

If under 24 hours

Hours

Minutes

14 Usual Occupation:

Housewife

(Kind of work done during most of working life)

15 Industry or Business:

At home

16 Social Security No.

017-40-7878

17 BIRTHPLACE (City)

Melrose, Mass.

18 NAME OF FATHER

Eugene F. Berry

19 BIRTHPLACE OF FATHER (City)

Boston, Mass.

20 MAIDEN NAME OF MOTHER

Ada J. Emmott

21 BIRTHPLACE OF MOTHER (City)

Wakefield, Mass.

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Jan. 3, 1972

Received and filed

January 7, 1972

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
 WRITE PLAINLY, WITH UNFADING, BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
 THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



FORM R-301

be filed for burial permit  
with Board of Health  
or its Agent.

INSTRUCTIONS  
FOR  
MEDICAL CERTIFICATE

PRINT OR TYPE  
CAUSE OR CAUSES  
OF DEATH

do not enter  
more than one  
cause for each  
of (a), (b) and (c)

This does not mean  
the mode of dying,  
such as heart failure,  
asthenia, etc. It means  
the disease, or complica-  
tions which caused  
death.

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

Conditions contrib-  
uting to death but not  
related to the terminal  
disease condition given  
in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS



Worcester  
(County)

Southborough  
(City or Town)

Southborough  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #42

No. 7 Cordaville Road

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Marjorie F. (Fairbanks) McDonald  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) None

(a) Permanent Residence. No. 7 Cordaville Road, Southborough, Mass.

(City or town and State)

Length of stay: In place of death 73 years 6 months 27 days. In place of residence 73 years 6 months 27 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 30 1971  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Nov. 12, 1951, to Dec. 30, 1971.

I last saw her alive on Dec. 29, 1971, death is said to  
have occurred on the date stated above, at 3:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Disseminated Sclerosis

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS Chr. Pyelonephritis

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
19 yr

7 yr

Was autopsy performed? No  
What test confirmed diagnosis? Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone, M. D.  
(Address) 42 Main St., Southborough, Mass. Jan 1, 1972

6 Rural Cemetery Southborough, Mass.  
Place of Burial or Cremation (City or town)

DATE OF BURIAL Jan 3 1972

7 NAME OF  
FUNERAL DIRECTOR Donald G. Morris  
ADDRESS 40 Main St., Southborough, Mass.

Received and filed January 5, 1972

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Dr. Hugh J. McDonald  
(Husband's name in full)

12 AGE 73 Years 6 Months 27 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Housewife-Town Clerk Tax Col.  
(Kind of work done during most of working life)

14 Industry or Business Town Government

15 Social Security No. #031-26-7926

16 BIRTHPLACE (City) Southborough  
(State or country) Mass.

17 NAME OF  
FATHER Charles L. Fairbanks

18 BIRTHPLACE OF  
FATHER (City) Southborough  
(State or country) Mass.

19 MAIDEN NAME  
OF MOTHER Hermenie Bouthilet

20 BIRTHPLACE OF  
MOTHER (City) Montreal  
(State or country) P.Q. Canada

21 Informant Dr. Hugh J. McDonald  
7 Cordaville Road Southborough  
(Address) Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



JOHN F. X. DAVOREN  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS  
 COPY OF  
 MEDICAL EXAMINER'S  
 CERTIFICATE OF DEATH

Framingham  
 (City or Town making this return)

Registered No. ....

PLACE OF DEATH

Middlesex  
 (County)

Framingham  
 (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Conroy (Brady)  
 (First Name) (Middle Name) (Last Name)  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) #3

(a) Permanent Residence. No. 5 Ted Lane St. Southboro, Mass.  
 (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 7 1972  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Diabetes  
 Hypertension  
 Coronary disease

5 Accident, suicide, or homicide (specify) .....  
 Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....  
 Where did injury occur? .....  
 (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... While at work? .....  
 (How did injury occur?)

Manner of Injury .....  
 Nature of Injury .....  
 (Specify type of place)

Was autopsy performed? ..... no

Was disease or injury in any way related to occupation of deceased? ..... no

If so, specify ..... no

(Signed) Antonio A. Matarese, M. D.

(Print or Type Name) Framingham Date 1/7/ 1972

6 St. Joseph Cem, Boston, Mass.  
 Place of Burial or Cremation (City or Town)

DATE January 10, 1972

7 NAME OF FUNERAL DIRECTOR P.E. Murray  
 ADDRESS Boston, Mass.

8 Informant John J. Conroy  
 (Address) 5 Ted Lane, Southboro

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE MARRIED (write the word) WIDOWED DIVORCED UNKNOWN married

12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of John J. Conroy (Husband's name in full)

13 AGE 75 YEARS 11 MONTHS Days If under 24 hours Hours Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. 021 03 0007B

17 BIRTHPLACE (City) Somerville, Mass.  
 (State or country)

18 NAME OF FATHER Michael Brady

19 BIRTHPLACE OF FATHER (City) Ireland  
 (State or country)

20 MAIDEN NAME OF MOTHER Catherine Kelley

21 BIRTHPLACE OF MOTHER (City) Ireland  
 (State or country)

22 A TRUE COPY ATTEST: [Signature]  
 (Register of City or Town where death occurred)

DATE FILED January 10, 1972

Received and filed February 9, 1972  
 Paul J. Berry, Town Clerk  
 (Registrar of City or Town where deceased resided)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

PLACE OF DEATH

**Middlesex**  
(County)  
**Framingham**  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. **#4**

No. **Kathleen Daniel Nursing Home** St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)  
**PHYSICIAN—IMPORTANT**

2 FULL NAME **Marcia E. George** { (If deceased a U. S. War Veteran, specify WAR) **no**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. **Lynbrook Rd.** St. **Southboro, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 10, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **Jan. 3, 1972** to **Jan. 10, 1972**  
I last saw him live on **Jan. 8, 1972** Death is said to have occurred on the date stated above, at **4:25 PM.**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Arteriosclerotic heart disease**

Due To  
(b)

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS **Arteriosclerosis, cerebral, with dementia**

INTERVAL BETWEEN ONSET AND DEATH  
**10 Yrs.**

Was autopsy performed? **No**

What test confirmed diagnosis? **Clinical course**

5 Was disease or injury in any way related to occupation of deceased? **No**

If so, specify

(Attending Physician) **Timothy P. Stone**, M.D.

(Address) **Southboro, Mass. 1/10 72**

6 **Newton Crem., Newton, Mass.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Jan. 13, 1972**

7 NAME OF FUNERAL DIRECTOR **George A. Mitchell**  
ADDRESS **Natick, Mass.**

8 Informant **Mr. Philip G. Jacobs**  
(Address) **Lynbrook Rd., Southboro, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word) **Single**  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

AGE **77** Years **5** Months **26** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **At home**  
(Kind of work done during most of working life)

15 Industry or Business **Farming**

16 Social Security No.

17 BIRTHPLACE (City) **Lee, Mass.**  
(State or country)

18 NAME OF FATHER **Albert E. George**

19 BIRTHPLACE OF FATHER (City) **New York, N.Y.**  
(State or country)

20 MAIDEN NAME OF MOTHER **Harriet Fish**

21 BIRTHPLACE OF MOTHER (City) **Lee, Mass.**  
(State or country)

A TRUE COPY  
ATTEST: **Michael J. Berry**  
(Registrar of City or Town where death occurred)

DATE FILED **Jan. 14, 1972**

Received and filed **February 9, 1972**  
**Paul J. Berry**  
Paul J. Berry, Town Clerk  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

20M-9-70-047762

PLACE OF DEATH

Middlesex

(County)

Marlborough

(City or Town)

The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

17

Registered No. ....

#1

No. **Marlboro Hospital** St. (If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME **Ruth (Osborn) McNamara**  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) **none**(a) Permanent Residence. No. **6 Bryden Road** St. **Southborough, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **January 15, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

**Smoke inhalation due to house fire**5 Accident, suicide, or homicide (specify) **accident**  
Date and hour of injury **7:00pm Jan. 15 19 72**  
IF ACCIDENTAL, was injury causally related to the death? **yes**  
Where did Injury occur? **Southboro, Mass.**  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? **Home** While at work? **no**  
(How did injury occur?)Manner of Injury **Found dead in bedroom of burning house**  
(Specify type of place)  
Nature of Injury **smoke inhalation**Was autopsy performed? **no**Was disease or injury in any way related to occupation of deceased? **no**

If so, specify .....

(Signed) **R. N. Rittenhouse**, M. D.(Address) **Marlboro, Mass.** Date **Jan. 15 19 72**  
(Print or Type Name)6 **Rural Crematory, Worcester, Mass.**  
Place of Burial or Cremation (City or Town)DATE **January 18 19 72**7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**  
ADDRESS **40 Main St. Southboro, Mass.**8 Informant **Robert C. McNamara**  
(Address) **6 Bryden Rd. Southboro, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word) **Widowed**  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of **Walter J. McNamara**  
(Husband's name in full)13 AGE **46** YEARS **7** MONTHS **7** Days If under 24 hours  
Hours Minutes14 Usual Occupation: **Realtor**  
(Kind of work done during most of working life)15 Industry or Business: **Real Estate**16 Social Security No. **094 20 0323**17 BIRTHPLACE (City) **Ithaca, New York**  
(State or country)18 NAME OF FATHER **Robert C. Osborn**19 BIRTHPLACE OF FATHER (City) **Lisle, New York**  
(State or country)20 MAIDEN NAME OF MOTHER **Agda Swenson**21 BIRTHPLACE OF MOTHER (City) **Sumitt, New Jersey**  
(State or country)A TRUE COPY  
ATTEST: **Peter C. Cotton**  
(City or Town where death occurred)DATE Agent **Jan. 17, 1972**Received and filed **January 26 1972**  
**Paul J. Berry, Town Clerk**  
(Registrar of City or Town where deceased resided)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Frammingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #5

No. Frammingham Union Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Ilma Johnson (Sessions)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR)

(a) Permanent Residence. No. 47 Oregon Road

St. Southborough, Mass.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Feb 19 1951 to Jan 20 1972  
last seen alive on Jan 20 1972, death is said to  
have occurred on the date stated above at 10am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary thrombosis

Due To

(b)

Arteriosclerotic heart dis.

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? ECG

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro Date 1/21/72

6 Rural Cemetery, Southboro, Mass.  
(Place of Burial or Cremation) (City or Town)

DATE OF BURIAL January 22, 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

8 Informant Dr. Peter V. Johnson

(Address) 47 Oregon Rd. Southboro

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN widowed

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Robert Hunt Johnson  
(Husband's name in full)

13 AGE 83 Years 0 Months 25 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business at home

16 Social Security No.

17 BIRTHPLACE (City) Whittier,  
(State or country) Calif.

18 NAME OF FATHER Henry Sessions

19 BIRTHPLACE OF FATHER (City) CNBL  
(State or country)

20 MAIDEN NAME OF MOTHER Jennie Patchen

21 BIRTHPLACE OF MOTHER (City) CNBL  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED January 31, 1972

Received and filed February 9, 1972

Paul J. Berry, Town Clerk

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



FORM R-303

to be filed for burial permit  
with Board of Health  
or its Agent.

N. B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SONI-9-70-047760

PLACE OF DEATH

Worcester  
(County)

Southborough  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
**MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH**

(City or Town making this return)

Registered No. #2

No. 5 Pinecone Lane

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME Kenneth Sargent Kingsbury  
(First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) U. S. War Veteran

(a) Permanent Residence. No. 2 Patricia Drive Brunswick, Maine  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 20 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease  
presumably coronary  
occlusion (Found dead  
in bed)

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did  
injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? While at work?

(How did injury occur?)

Manner of  
injury

(Specify type of place)

Nature of  
injury

Was autopsy performed? NO

Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) S. Alden Guild M.D.

(Address) 5 Alden Guild M.D.

(Print or Type Name) S. Alden Guild M.D.

(Address) 5 Pinecone Lane, Southborough, Mass

6 RURAL Cemetery, Southborough, Mass

Place of Burial or Cremation (City or Town)

DATE Jan 23, 1972

7 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St., Marlboro, Mass

8 Informant Mrs. Barbara Audet (daughter)

(Address) 5 Pinecone Lane, Southborough, Mass

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR white 11 SINGLE MARRIED (write the word)  
DIVORCED UNKNOWN

12 If married, widowed or divorced  
HUSBAND of Anne Bennett  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 72 YEARS 2 MONTHS 27 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: Bank officer - Retired  
(Kind of work done during most of working life)

15 Industry or Business: First Nat'l Bank of Boston

16 Social Security No. 020-14-5534

17 BIRTHPLACE (City) Boston  
(State or country) Mass

18 NAME OF FATHER George Kingsbury

19 BIRTHPLACE OF FATHER (City) Millis  
(State or country) Mass

20 MAIDEN NAME OF MOTHER Ada Woods

21 BIRTHPLACE OF MOTHER (City) England  
(State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Amos Sima, Registrar  
(Signature of Agent Board of Health or other)

(Official Designation) 1-21-72  
(Date of Issue of Permit)

Received and filed January 26, 1972

Paul J. Berry, Town Clerk  
(Registrar)

A TRUE COPY

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT  
OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... *February 19, 1918* .....  
DATE OF DISCHARGE ..... *September 30, 1921* .....  
RANK, RATING ..... *Yeoman, 1st Class (Pay)* .....  
ORGANIZATION AND OUTFIT ..... *U.S. Navy P.F.* .....  
SERVICE NUMBER ..... *- None -* .....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile" "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

If the cause of death has not been determined at the time of the certification, item #4 should be noted "Undetermined — pending further investigation."

Immediately upon the completion of the investigation, a new form R-303 should be complete insofar as the medical portion is concerned (Items #1 through #6) signed and filed with the local clerk so that the original return may be completed by adding the cause of death to it.



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #6

No. Framingham Union Hospital St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Elizabeth Bruning (Lynch)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR)

(a) Permanent Residence, No. 44 Oak Hill Rd. St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 22 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from 12:15 71 to 1-22 72  
I last saw him alive on 1-22 72 death is said to have occurred on the date stated above, at 1:30 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hyperosmolar Coma

Due To (b) Acute pancreatitis

Due To (c) diabetes milletus

OTHER SIGNIFICANT CONDITIONS Kummelsted Wilson disease

Was autopsy performed? Yes

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

John E. Hoyer  
(Attending Physician) M.D.

(Address) Framingham Date 1-23 72

6 Edgell Grove Cem., Framingham  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 25 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southborough, Mass.

8 Informant Paul U. Bruning  
(Address) Southborough, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR W 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Paul U. Bruning (Husband's name in full)

13 AGE 37 Years 5 Months 25 Days | If under 24 hours Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 031-28-8060

17 BIRTHPLACE (City) Framingham  
(State or country) Mass.

18 NAME OF FATHER Dr. George W. Lynch

19 BIRTHPLACE OF FATHER (City) Framingham  
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Anne V. Fors

21 BIRTHPLACE OF MOTHER (City) Sweden  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 1-26-72 19

Received and filed February 9 1972

Paul J. Barry Town Clerk  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



RM R-301

ed for burial permit  
Board of Health  
or its Agent.

INSTRUCTIONS FOR  
AL CERTIFICATE

INT OR TYPE  
SE OR CAUSES  
OF DEATH  
INFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asphy-  
It means the disease, or  
itions which caused death.  
tions, if any, which gave  
above cause (a), stating the  
ng cause last.

itions contributing to death  
related to the terminal dis-  
condition given in (a).

1991  
X 71

M R-301. 10GM-5-71-049420

## OUT - OF - TOWN

1 PLACE OF DEATH  
Suffolk  
(County)  
Boston  
(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 00885

No. New England Baptist Hospital St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Edmund L. Kelley  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(If deceased a  
U. S. War Veteran, specify WAR) W.W.II

(a) Permanent Residence. No. 355 Webster St. Needham Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH	January 24 1972 (Month) (Day) (Year)	9 SEX	10 COLOR
4 I HEREBY CERTIFY, that I attended deceased from January 18, 1972, to January 24, 1972. I last saw him alive on January 24, 1972, death is said to have occurred on the date stated above, at 9:30 p.m.		M	W
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN	
(a) Metastatic cancer brain	INTERVAL BETWEEN ONSET AND DEATH 1 month	12 If married, widowed, or divorced HUSBAND of Lucy Fisher. (Give maiden name of wife in full)	
(b) primary brain		(or) WIFE of (Husband's name in full)	
(c) unknown		13 AGE 70 Years 10 Months 18 Days   If under 24 hours Hours Minutes	
OTHER SIGNIFICANT CONDITIONS		14 Usual Occupation Supervisor (Kind of work done during most of working life)	
Was autopsy performed? No		15 Industry or Business Railroad	
What test confirmed diagnosis? X-ray		16 Social Security No. 705-18-3554	
5 Was disease or injury in any way related to occupation of deceased? No		17 BIRTHPLACE (City) Southboro (State or country) Mass	
If so, specify		18 NAME OF FATHER Daniel F. Kelley	
(Signature) ALLAN L. DAVIS M.D.		19 BIRTHPLACE OF FATHER (City) Hopkinton (State or country) Mass	
(Address) 50 Commonwealth Ave Boston	(Print or Type Name) Date 1/25 1972	20 MAIDEN NAME OF MOTHER Julia Callanan	
6 Rural Cemetery Southboro (Place of Burial or Cremation) (City or Town)		21 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass	
DATE OF BURIAL Jan 27 1972		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued. Eugene E. Leonard 508705 (Signature of Agent Board of Health or other) Jan 26 1972 (Official Designation) (Date of Issue of Permit)	
7 NAME OF FUNERAL DIRECTOR Eaton Funeral Home ADDRESS 1351 Highland Ave Needham		Received and filed JAN 31 1972 1972	
8 Informant Mrs. Lucy Kelley (Address) 355 Webster St. Needham		A TRUE COPY ATTEST: (Registrar)	



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Franklinham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #9

No. Meadowbrook Manor

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Marguerite E. Knight  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 10 Middle Rd.

St. Southboro, Mass.  
(City or Town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 4, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
12-5-49, to 2-4-72  
I last saw him alive on 2-2-72 death is said to  
have occurred on the date stated above, at 11:45 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia

Due To

(b) Subdural hematoma

Due To

(c) a fall 12-30-71

OTHER  
SIGNIFICANT  
CONDITIONS

Multiple myeloma

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

6das.

5wks.

36das

26mos

Was autopsy performed? no

What test confirmed diagnosis? Clinical course

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro Date 2-4-72

6 Place of Burial or Cremation Rural Cemetery Southboro  
(City or Town)

DATE OF BURIAL February 7, 1972

7 NAME OF FUNERAL DIRECTOR T. F. Callanan

ADDRESS Hopkinton, Mass.

8 Informant Blanche Rhodes

(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

F W Single

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 75 Years 1 Months 11 Days If under 24 hours  
.....Hours.....Minutes

14 Usual Occupation Secretary  
(Kind of work done during most of working life)

15 Industry or Business United Farmers

16 Social Security No. 024-03-3444A

17 BIRTHPLACE (City) Whitefield  
(State or country) Maine

18 NAME OF FATHER Charles Knight

19 BIRTHPLACE OF FATHER (City) Maine  
(State or country)

20 MAIDEN NAME OF MOTHER Annie Ryan

21 BIRTHPLACE OF MOTHER (City) Marlboro  
(State or country) Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 2-7-72 19

Received and filed 3/13/72 19

Paul J. Berry, Town Clerk  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham

(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

Framingham Union Hospital

No. ....

COPY OF

CERTIFICATE OF DEATH

Registered No. ....

#10

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME

John Guligauskas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

13 Moulton Rd.

(a) Permanent Residence, No. ....

St. ....

Southboro, Mass.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I deceased from  
in 1972, 2-18-72  
I last saw him alive on 2-18-72, death is said to  
have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

Due To

(b) 1) Chronic obstructive pulmonary

(c) Dis., 2) Flu syndrome

OTHER  
SIGNIFICANT  
CONDITIONS

no

Was autopsy performed?

Clinical data

What test confirmed diagnosis?

no

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

Clarence Brown

(Attending Physician) ....., M.D.

Natick

2-20

72

(Address) ..... Date ..... 19.....

Rural Cemetery

Southborough

6 Place of Burial or Cremation February 22 or Town) 72

DATE OF BURIAL ..... 19.....

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

Southborough, Mass.

ADDRESS

8 Informant Mrs. Helen Guligauskas

(Address) Southborough, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR W 11 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, divorced or

HUSBAND of

Helen Navickas

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 83 Years 4 Months 26 Days | If under 24 hours  
Hours Minutes

14 Usual

Occupation

Meat cutter

(Kind of work done during most of working life)

15 Industry  
or Business

Packing houses

16 Social Security No.

013-07-4828

17 BIRTHPLACE (City)  
(State or country)

Lithuania

18 NAME OF  
FATHER

Jonas Guligauskas

19 BIRTHPLACE OF  
FATHER (City)  
(State or country)

Lithuania

20 MAIDEN NAME  
OF MOTHER

Maria Nakitinis

21 BIRTHPLACE OF  
MOTHER (City)  
(State or country)

Lithuania

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

2-23-72

19.....

Received and filed

3-13-72

19.....

Paul J. Berry, Town Clerk

(Registrar of City or Town where deceased resided)



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

1 PLACE OF DEATH

Worcester  
(County)

Southboro  
(City or Town)

No. 249 Parkerville Rd.

## STANDARD CERTIFICATE OF DEATH

Registered No. 117

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(If deceased a  
U. S. War Veteran,  
specify WAR) No

2 FULL NAME Kerras H. Campbell  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. " 249 Parkerville Rd. St. Southboro, Mass.  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 26, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Sept. 14, 1970, to February 26, 1972.  
I last saw him alive on February 26, 1972, death is said to  
have occurred on the date stated above, at 7:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To

(b) Atherosclerosis, Coronary

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Cerebral Thrombosis

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

10 1/2 hrs

11 yrs

5 1/2 yrs

Was autopsy performed? No  
What test confirmed diagnosis? Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone, M. D.

(Print or Type Name)

(Address) 42 Main St., Southboro Date Feb. 27 1972

6 Rural Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 29, 1972

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62 W. Main St. Westboro, Mass.

8 Informant Mrs. Kerras H. Campbell

(Address) 249 Parkerville Rd. Southboro, Mass.

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of Mildred F. Drake  
(Give maiden name of wife in full)  
(or) WIFE of  
(Husband's name in full)

13 AGE 69 Years Months 5 Days If under 24 hours  
Hours Minutes

14 Usual Occupation Press Operator  
(Kind of work done during most of working life)

15 Industry or Business Bay State Abrasives Co.

16 Social Security No. 034-16-7365 A.

17 BIRTHPLACE (City) Summerside  
(State or country) Prince Edward Island

18 NAME OF FATHER David Campbell

19 BIRTHPLACE OF FATHER (City) New London  
(State or country) Prince Edward Island

20 MAIDEN NAME OF MOTHER Eliza Hardy

21 BIRTHPLACE OF MOTHER (City) Montrose  
(State or country) Prince Edward Island

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:  
Mrs. Susan A. McKeown  
(Signature of Agent Board of Health or other)

2-28-72  
(Official Designation) (Date of Issue of Permit)

Received and filed March 1, 1972

Paula Berry, Town Clerk (Registrar)

A TRUE COPY ATTEST:

M R-301

d for burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
L CERTIFICATE

NT OR TYPE  
E OR CAUSES  
F DEATH

o not enter  
ore than one  
se for each  
(a), (b) and (c)

does not mean  
ode of dying,  
to heart failure,  
ia, etc. It means  
eas, or compli-  
s which caused

itions, if any,  
t gave rise to  
s cause (a),  
g the under-  
cause last.

itions contrib-  
to death but not  
l to the terminal  
condition given  
).



Filed for burial permit  
by Board of Health  
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 5, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M1-9-70-047760

PLACE OF DEATH

1 Worcester  
(County)  
Southborough  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Registered No. #8

No. 116 Main

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME

Charles

Sumner

Barton

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR)

(a) Permanent Residence. No. 116 Main Street

St. Southborough, Mass.

(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF

DEATH

March

4

1972

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease,  
presumably coronary occlusion  
(Found dead in bed)

5 Accident, suicide, or homicide (specify)

Date and hour of injury

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? While at work?

(How did injury occur?)

Manner of

Injury

(Specify type of place)

Nature of

Injury

Was autopsy performed? No

Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

S. Alden Guild

M. D.

(Address) Grafton (Print or Type Name) Date March 4, 1972

6 Rural Cemetery Southborough, Mass.  
Place of Burial or Cremation (City or Town)

DATE March 7, 1972

7 NAME OF

FUNERAL DIRECTOR

Donald C. Morris

ADDRESS

40 Main St. Southborough, Mass.

8 Informant

Charles S. Barton, Jr.

(Address)

116 Main St. Southborough, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

M

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

12 If married, widowed or divorced

HUSBAND of Mary E. McConologue

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE

59 YEARS 4 MONTHS 25 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation: Chmn. of the Board

(Kind of work done during most of working life)

15 Industry

or Business: Rice Barton Corp. Worc. Mass.

16 Social Security No.

034-09-9016

17 BIRTHPLACE (City)

Worcester

(State or country)

Mass.

18 NAME OF

FATHER George Sumner Barton

19 BIRTHPLACE OF

FATHER (City) Worcester

(State or country)

Mass.

20 MAIDEN NAME

OF MOTHER Elizabeth Lincoln

21 BIRTHPLACE OF

MOTHER (City) Worcester

(State or country)

Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan A. Colette - Agent  
(Signature of Agent Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

Received and filed

March 8,

1972

Paul J. Berry, Town Clerk (Registrar)

A TRUE COPY ATTEST:



1 for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

TYPE OR TYPE  
OR CAUSES  
OF DEATH

not enter  
more than one  
cause for each  
(a), (b) and (c)

does not mean  
mode of dying,  
heart failure,  
etc. It means  
cause, or compli-  
which caused

itions, if any,  
h gave rise to  
e cause (a),  
ing the under-  
cause last.

ditions contrib-  
to death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #11

Worcester  
(County)  
Southborough  
(City or Town)



No. 116 Southville Road  
(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lillian M. (Campbell) O'Donnell  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 116 Southville Road s. Southborough, Mass.  
(City or town and State)

Length of stay: In place of death 15 years months days. In place of residence 15 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 20 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
3/19, 1972, to 3/20, 1972.

I last saw her alive on 3/19/1972, death is said to  
have occurred on the date stated above, at 11 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Failure

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1mo

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Car of colon 15 yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Mary M. Masure, M. D.

(Print or Type Name) Mary M. Masure

(Address) 81 Middle Rd. Date 3/21/72

Mass

6 St. Bridgets cemetery Maynard  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 24 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street Southborough, Mass.  
ADDRESS

Received and filed March 24, 1972

Paul J. Berry

Paul J. Berry, Town Clerk

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William H. O'Donnell  
(Husband's name in full)

12 AGE 90 Years 8 Months 19 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business at Home

15 Social Security No. 021-03-8129

16 BIRTHPLACE (City) Sudbury  
(State or country) Mass.

17 NAME OF FATHER William Campbell

18 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Elizabeth Carr

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.

21 Informant Mrs. Ruth Perini  
116 Southville Road Southborough  
(Address) Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan G. O'Connell

(Signature of Agent of Board of Health or other)

3/23/72  
(Date of Issue of Permit)

A TRUE COPY ATTEST:



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

20M-9-70-047762

PLACE OF DEATH

Middlesex  
Frammingham



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town) Frammingham

Registered No. #15

No. Frammingham Union Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME (First Name) Stephen (Middle) Mann (Last) MacNeille  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 3 Granuaile Road

St. Southboro, Mass.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) March (Day) 23 (Year) 1972

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute heart failure secondary to hypertensive cardiovascular disease.

5 Accident, suicide, or homicide (specify) Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death? Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? While at work? (How did injury occur?)

Manner of Injury (Specify type of place) Nature of Injury

Was autopsy performed? no Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Luke G. Tedeschi, M. D. (Print or Type Name) (Address) Frammingham Date 3/23/72

6 Place of Burial or Cremation Newton Crematory, Newton, Mass.

DATE March 27 1972

7 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth ADDRESS Frammingham, Mass.

8 Informant Mrs. Bess MacNeille (Address)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE MARRIED (write the word) WIDOWED DIVORCED UNKNOWN married

12 If married, widowed, or divorced Bess Kraly HUSBAND of (Give maiden name of wife in full)

(WIFE of (Husband's name in full)

13 AGE 60 YEARS 1 MONTHS 26 Days If under 24 hours Hours Minutes

14 Usual Occupation: Physicist (Kind of work done during most of working life)

15 Industry or Business: American Optical Co. 118 03 7176

16 Social Security No. Newark, New Jersey

17 NAME OF FATHER Perry MacNeille

18 BIRTHPLACE OF FATHER (City) Conn (State or country)

19 MAIDEN NAME OF MOTHER Clausine Mann

20 BIRTHPLACE OF MOTHER (City) New Jersey (State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED March 28, 1972

Received and filed May 8, 1972

(Registrar of City or Town where deceased resided)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

NEWTON

(City or Town making this return)

(Southborough #20)

174-72

COPY OF

## CERTIFICATE OF DEATH

Registered No. ....

MIDDLESEX

NEWTON

(City or Town)

Newton-Wellesley Hospital

No. .... St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

Louise M. Prosperi

2 FULL NAME ..... (If deceased a U. S. War Veteran, specify WAR) None

(a) Permanent Residence, No. .... St. .... (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH ..... (Month) ..... (Day) ..... (Year) .....  
4 I HEREBY CERTIFY, that ..... attended deceased from ..... 19....., to ..... 19....., death is said to have occurred on the date stated above, at ..... m.  
DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Cardiorespiratory Failure

(a) Cerebral Embolism 6 Days  
(b) Rheumatic Heart Disease Years  
(c) OTHER SIGNIFICANT CONDITIONS No

Was autopsy performed? None - Clinical  
What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify Gustave A. Laurenzi M.D.  
2000 Washington St. Newton, Mass. 3-27 72 M.D.

(Address) Rural Cemetery Southboro, Mass. 19.....

6 Place of Burial or Cremation March 29 72 (City or Town)  
DATE OF BURIAL Donald C. Morris 19.....

7 NAME OF FUNERAL DIRECTOR 10 Main St. Southboro, Mass.  
ADDRESS Louis Prosperi

8 Informant 78 Newton St. Southboro, Mass.  
(Address) Jurisdiction declined by Medical Examiner

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) Single  
12 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)  
(or) WIFE of ..... (Husband's name in full)  
13 AGE 36 Years 9 Months 25 Days If under 24 hours Hours Minutes  
14 Usual Occupation Secretary (Kind of work in which deceased was engaged)  
15 Industry or Business 017-28-5294  
16 Social Security No. Southboro Mass.  
17 BIRTHPLACE (City) (State or country) Louis Prosperi  
18 NAME OF FATHER Pesaro  
19 BIRTHPLACE OF FATHER (City) (State or country) Italy  
20 MAIDEN NAME OF MOTHER Eliza Magi  
21 BIRTHPLACE OF MOTHER (City) (State or country) Pesaro Italy

A TRUE COPY  
ATTEST: Joseph H. Kishm (Registrar of City or Town where death occurred)  
DATE FILED March 28 19 72  
Received and filed June 12 19 72  
Paul J. Southboro, Mass. (Registrar of City or Town where deceased resided)



For burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

NT OR TYPE  
E OR CAUSES  
F DEATH

o not enter  
ore than one  
use for each  
, (b) and (c)

does not mean  
mode of dying,  
as heart failure,  
ia, etc. It means  
cause, or compli-  
which caused

ditions, if any,  
h gave rise to  
e cause (a),  
ng the under-  
cause last.

conditions contrib-  
to death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #13

PLACE OF DEATH

Worcester  
(County)

Southborough  
(City or Town)

No. 16 Moulton Road

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie B. (Beckingham) Hennessey  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) None

(a) Permanent Residence. No. 16 Moulton Road st. Southborough, Mass.  
(City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 2 years 6 months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 5, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
May 29, 1969, to April 5, 1972  
I last saw her alive on March 8, 1972, death is said to  
have occurred on the date stated above, at 7:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

2 yrs

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Arteriosclerosis, general

12 yrs

Was autopsy performed? no

What test confirmed diagnosis? hospital study Feb. 72

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Timothy P. Stone, M. D.

TIMOTHY P. STONE

(Print or Type Name)

(Address) 42 Main St., Southboro Date April 5, 1972

St. Marys Cemetery Dover N.H.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 8, 1972

7 NAME OF FUNERAL DIRECTOR McCooey-Dion

114 Locust St. Dover N.H.

ADDRESS

(Received and filed April 7, 1972)

Paul J. Berry, Town Clerk

(Registrar)

A TRUE COPY ATTEST:

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Frank V. Hennessey  
(Husband's name in full)

12 AGE 79 Years 9 Months 21 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business at Home

15 Social Security No. 002-03-7582

16 BIRTHPLACE (City) Dover (State or country) N.H.

17 NAME OF FATHER Patrick Beckingham

18 BIRTHPLACE OF FATHER (City) County Armagh (State or country) Ireland

19 MAIDEN NAME OF MOTHER Elizabeth Casey

20 BIRTHPLACE OF MOTHER (City) County Armagh (State or country) Ireland

21 Informant Mrs. Ann Brennan

16 Moulton Road Southborough, Mass.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



d for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

NT OR TYPE  
E OR CAUSES  
F DEATH

o not enter  
ore than one  
use for each  
(a), (b) and (c)

does not mean  
mode of dying,  
as heart failure,  
ia, etc. It means  
sease, or compli-  
which caused

ditions, if any,  
h gave rise to  
e cause (a),  
ing the under-  
g cause last.

onditions contrib-  
to death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #12

PLACE OF DEATH

Worcester  
(County)

Southborough  
(City or Town)

No. 1 Fisher Road

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **JULIA M. O'CONNELL**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, None  
if so specify WAR)

(a) Permanent Residence. No. 1 Fisher Road st. Southborough, Mass.  
(City or town and State)

Length of stay: In place of death 96 years 7 months 20 days. In place of residence 96 years 7 months 20 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **APRIL 5 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**April 3 1972 to April 5 1972**

I last saw him alive on **April 4 1972**, death is said to  
have occurred on the date stated above, at **12:30 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Adenocarcinoma, Breast, right.**

(b) **(first revealed March 29, 1972)**

(c)

OTHER SIGNIFICANT CONDITIONS **Mediastinal Metastases.**

Was autopsy performed? **No**  
What test confirmed diagnosis? **Clinical Appearance.**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify

(Signature) **Timothy P. Stone**, M. D.  
**TIMOTHY P. STONE**  
(Print or Type Name)

(Address) **42 Main St., Southboro** Date **April 5 1972**

Immaculate Conception Marlboro, Mass

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **April 7 1972**

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**

**40 Main Street**  
ADDRESS **Southborough, Mass.**

Received and filed **April 7 1972**

**Paul J. Berry, Town Clerk**

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **F** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED Single**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 **96** Years **7** Months **20** Days If under 24 hours  
Hours Minutes

13 Usual Occupation **Seamstress**  
(Kind of work done during most of working life)

14 Industry or Business **Fay School**

15 Social Security No. **019-36-1542**

16 BIRTHPLACE (City) **Southborough**  
(State or country) **Mass.**

17 NAME OF FATHER **David O'Connell**

18 BIRTHPLACE OF FATHER (City) **Middleton**  
(State or country) **Ireland**

19 MAIDEN NAME OF MOTHER **Hannah Toomey**

20 BIRTHPLACE OF MOTHER (City) **Queenstown**  
(State or country) **Ireland**

21 Informant **Miss Margaret M. O'Connell**

**1 Fisher Road Southborough, Mass.**  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATHRegistered No. **03271**

PLACE OF DEATH

**SUFFOLK**

(County)

**BRIGHTON**

(City or Town)

No.

**ST. ELIZABETHS HOSP.**{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

**LINDA PARSONS**

(ROUBIK)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No #23

(a) Permanent Residence. No.

**9 JOHN ST.**St. **SOUTH BORO MASS.**

(City or town and State)

Length of stay: In place of death — years — months — days. In place of residence — years — months — days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH**APRIL****10TH****1972**

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

**MARCH 30****1972****APRIL****10TH****1972**I last saw him alive on **APRIL 10TH** 1972 death is said tohave occurred on the date stated above, at **9:07 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cardiovascular arrest**

Due To

**HARDEN'S DISEASE**

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? **YES**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? **YES**

If so, specify

(Signature)

**Leon J. Jackson**  
**LEON J. JACKSON**

M. D.

(Print or Type Name)

(Address)

**ST. ELIZABETHS**

Date

**APRIL 10, 1972**6 **Newton Crematory, Newton, Mass**

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

**April 13,**

1972

7 NAME OF

**George O'Dea**

FUNERAL DIRECTOR

**Lacy Funeral Home**

ADDRESS

**129 Harvard St. Brookline**

Received and filed

**APR 18 1972**

A TRUE COPY ATTEST:

July 7, 72

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

**Female**

9 COLOR

**White**

10 SINGLE (write the word)

**MARRIED****WIDOWED****DIVORCED****UNKNOWN****Married**

11 If married, widowed, or divorced

HUSBAND of

**David J.M. Parsons**

(or) WIFE of

(Husband's name in full)

12

**25**

AGE

Years

Months

Days

If under 24 hours

Hours

Minutes

13 Usual

Occupation

**School Teacher**

(Kind of work done during most of working life)

14 Industry

or Business

**Southboro Elementary Schools**

15 Social Security No.

16 BIRTHPLACE (City)

**Hinsdale, Illinois**

(State or country)

17 NAME OF

FATHER

**Edward Roubik**

18 BIRTHPLACE OF

FATHER (City)

**Chicago, Illinois**

(State or country)

19 MAIDEN NAME

OF MOTHER

**Elizabeth Lindblom**

20 BIRTHPLACE OF

MOTHER (City)

**Kansas**

(State or country)

21 Informant

(Address)

**David Parsons (Husband)****9 John St. Southboro, Mass.**I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

**011253**  
(Official Designation)**April 12, 1972**  
(Date of Issue of Permit)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

Marlborough  
(City or Town making this return)

#14

COPY OF  
CERTIFICATE OF DEATH

Registered No. 94

PLACE OF DEATH

Middlesex  
(County)Marlborough  
(City or Town)

No. Marlboro Hospital

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Norman J. Zkiab

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR) no

(a) Permanent Residence, No. 8 Mitchell

St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 12, 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from  
June 1970, to April 12, 1972  
I last saw him live on April 12, 1972  
death is said to  
have occurred on the date stated above, at 11:30p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) acute coronary occlusion 36 hrs

Due To (b) Arteriosclerotic heart dis. 3 yrs

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Diabetes mellitus

Was autopsy performed? yes

What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) R. N. Rittenhouse, M.D.

(Address) Marlboro, Mass. Date Apr. 14, 1972

6 Rural Cemetery Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 15, 1972

7 NAME OF FUNERAL DIRECTOR Donal C. Morris

ADDRESS 40 Main St. Southboro, Mass.

8 Informant Mrs. Mabel Sampson

(Address) 8 Mitchell St. Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Widowed12 If married, widowed, or divorced  
HUSBAND of Mary Hakim  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

AGE 79 Years 10 Months 27 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Shoemaker  
(Kind of work done during most of working life)

15 Industry or Business retired

16 Social Security No. 011 01 1225

17 BIRTHPLACE (City)  
(State or country) Lebanon

18 NAME OF FATHER Joseph Zkiab

19 BIRTHPLACE OF FATHER (City)  
(State or country) Lebanon

20 MAIDEN NAME OF MOTHER Cannot be learned

21 BIRTHPLACE OF MOTHER (City)  
(State or country) Lebanon

A TRUE COPY

ATTEST: Peter P. Cottone  
(Registrar of City or Town where death occurred)

DATE FILED April 14, 1972

Received and filed April 14, 1972  
Paul J. Berry  
(Registrar of City or Town where deceased resided) April 27, 1972MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

**Framingham**  
 (City or Town making this return)

Middlesex

(County)

Framingham

(City or Town)



COPY OF

CERTIFICATE OF DEATH

Registered No. #16

Kathleen Daniel Nursing Home

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 PHYSICIAN—IMPORTANT

Catherine J. Molloy (Friel)

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.) No (If deceased a U. S. War Veteran, specify WAR)

13 Pinecone Lane

(a) Permanent Residence, No. St. Southboro, Mass.  
 (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 13, 1972  
 (Month) (Day) (Year)

DECEASED CERTIFY, that I attended deceased from Dec. 30, 1971, to Apr. 13, 1972, 1972.  
 I last saw him alive on Apr. 13, 1972, death is said to have occurred on the date stated above, at 2:55P. m.

DEATH WAS CAUSED BY IMMEDIATE CAUSE  
 vascular disease with gangrene  
 (a)

Due To Arteriosclerosis generalized  
 (b)

Due To Coronary artery disease  
 (c)

OTHER SIGNIFICANT CONDITIONS  
 10Yrs

Was autopsy performed? Clinical  
 What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
 If so, specify

John E. Hoyer  
 (Attending Physician) M.D.

Framingham, Mass. 4/13 72  
 (Address) Date

St. Josephs Cem., Boston, Mass.

6 Place of Burial or Cremation Apr. 17, 72  
 DATE OF BURIAL (City or Town)

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
 ADDRESS Southboro, Mass.

8 Informant Martin J. Molloy, Jr.  
 (Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of Martin J. Molloy (Maiden name in full)

(or) WIFE of (Husband's name in full)

13 AGE 77 Years 3 Months 9 Days If under 24 hours Hours Minutes

14 Usual Occupation Housewife  
 (Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 031-14-8588

17 BIRTHPLACE (City) Ireland  
 (State or country)

18 NAME OF FATHER John Friel

19 BIRTHPLACE OF FATHER (City) Ireland  
 (State or country)

20 MAIDEN NAME OF MOTHER Catherine Judge

21 BIRTHPLACE OF MOTHER (City) Ireland  
 (State or country)

A TRUE COPY  
 ATTEST: Michael J. Wood  
 (Registrar of City or Town where death occurred)  
 4/14 72

DATE FILED May 8, 1972

Received and filed Paul J. Berry  
 (Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
 WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
 THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)



**Middlesex**

(County)

**Framingham**

(City or Town)

COPY OF

CERTIFICATE OF DEATH

Registered No. ....

#17

No. **Framingham Union Hospital** St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)  
**PHYSICIAN—IMPORTANT**

2 FULL NAME **Philomena Barlow (Statuto)** { (If deceased a U. S. War Veteran, specify WAR) **No**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. **104 Main** St. **Southboro, Mass.**  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 23, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **March 19, 58** to **April 23, 72**  
I last saw her alive on **April 23, 1972** death is said to have occurred on the date stated above, at **9:55P.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Coronary occlusion, myocardial infarction**

Due To (b) **Diabetes mellitus**

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS **Megacolon**

Was autopsy performed? **Yes**

What test confirmed diagnosis? **Clinical & autopsy**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify .....

**Robert E. Johnson,**  
(Attending Physician) ....., M.D.

(Address) **Framingham, Mass. 4/25 72**

6 **St. Michael's Cem., Hudson, Mass.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Apr. 26, 1972**

7 NAME OF FUNERAL DIRECTOR **Hickey Funeral Home**  
**Hudson, Mass.**

8 Informant **Mrs. Paul Honen**  
(Address) **Yarmouth, Mass.**

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

12 If married, widowed, or divorced  
HUSBAND of .....  
(Give maiden name of wife in full)

(or) WIFE of **John E. Barlow**  
(Husband's name in full)

13 AGE **73** Years **5** Months **4** Days | If under 24 hours  
Hours ..... Minutes

14 Usual Occupation **At home**  
(Kind of work done during most of working life)

15 Industry or Business **Housekeeper**

16 Social Security No. **Railroad retirement**

17 BIRTHPLACE (City) **Lowell,**  
(State or country) **Mass.**

18 NAME OF FATHER **Peter Statuto**

19 BIRTHPLACE OF FATHER (City) .....  
(State or country) **Italy**

20 MAIDEN NAME OF MOTHER **Mary Therrien**

21 BIRTHPLACE OF MOTHER (City) .....  
(State or country) **Canada**

A TRUE COPY

ATTEST: .....  
(Registrar of City or Town where death occurred)

DATE FILED **Apr. 27, 1972**

Received and filed **May 8, 1972**

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

#18

COPY OF  
CERTIFICATE OF DEATH

Registered No. ....

No. **Framingham Union Hospital** St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME **Helen Guligauskas (Navickas)** { (If deceased a  
U. S. War Veteran,  
specify WAR) **No**

(a) Permanent Residence, No. **13 Moulton Rd.** St. **Southboro, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 26, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended, deceased, from  
**Jan. 70** to **Apr. 26, 1972**  
I last saw her alive on **Apr. 26, 1972**, death is said to  
have occurred on the date stated above, at **8:00 A.M.**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Internal small bowel hernia 15 hrs.**  
(b) **various infarctions**

Due To  
(c)

OTHER SIGNIFICANT  
CONDITIONS **Deforming rheumatoid  
arthritis**

Was autopsy performed? **Yes**  
What test confirmed diagnosis? **Autopsy**

5 Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify

**Clarence Brown,**  
(Attending Physician) ....., M.D.

**Natick, Mass.** **4/26** **72**  
(Address) ....., Date ....., 19 .....

6 **Rural Cem., Southboro, Mass.**  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL **Apr. 28,** **72**  
19 .....

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**  
**Southboro, Mass.**  
ADDRESS

8 Informant **Mrs. Ellen Mackey**  
**Southboro, Mass.**  
(Address)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

12 If married, widowed, or divorced  
HUSBAND of **John Guligauskas** (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE **77** Years **0** Months **11** Days | If under 24 hours  
..... Hours ..... Minutes

14 Usual Occupation **Housewife**  
(Kind of work done during most of working life)

15 Industry or Business **At home**

16 Social Security No. **024-07-2153A**

17 BIRTHPLACE (City) **Lithuania**  
(State or country)

18 NAME OF FATHER **John Navickas**

19 BIRTHPLACE OF FATHER (City) **Lithuania**  
(State or country)

20 MAIDEN NAME OF MOTHER **Helen Kasilenas**

21 BIRTHPLACE OF MOTHER (City) **Lithuania**  
(State or country)

A TRUE COPY **Michael J. Ward**  
ATTEST: (Registrar of City or Town where death occurred)  
**May 1,** **72**

DATE FILED 19 .....

Received and filed **May 8, 1972** 19 .....

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



Filed for burial permit with Board of Health or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

504-5-71-049420

PLACE OF DEATH

NORFOLK  
(County)  
BROOKLINE  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

BROOKLINE  
(City or Town making this return)  
#19 (Southborough)  
Registered No. 148

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

No. 910 Boylston St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
2 FULL NAME Mary Elizabeth Reeves Mussey  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) None  
(a) Permanent Residence. No. 11 Granvaile Rd Southboro, Massachusetts  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH April 30 1972 (Month) (Day) (Year)	9 SEX Female	10 COLOR White	11 SINGLE MARRIED (write the word) WIDOWED DIVORCED UNKNOWN Married
4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.) Carcinoma Left Breast with Metastases		12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Delavan S. Mussey (Husband's name in full)	
5 Accident, suicide, or homicide (specify) _____ Date and hour of injury _____ 19____ IF ACCIDENTAL, was injury causally related to the death? _____ Where did injury occur? _____ (City or town and State) Did injury occur in or about home, on farm, in industrial place, or in public place? _____ While at work? _____ (How did injury occur?) Manner of injury _____ Nature of injury _____ (Specify type of place) Was autopsy performed? _____ Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) Paul H. Gates, M. D. 628 High St., Dedham, Mass (Print or Type Name) 4-30 1972 (Address) _____ Date _____ 19____		13 AGE 58 Years 5 Months 19 Days If under 24 hours _____ Hours _____ Minutes _____ 14 Usual Occupation: Clerk (Kind of work done during most of working life) 15 Industry or Business: Oil Business 16 Social Security No. 088-07-1874 17 BIRTHPLACE (City) (State or country) New York, New York	
6 Forest Hills Crematory, Boston Place of Burial or Cremation (City or Town) DATE May 3, 1972		PARENTS 18 NAME OF FATHER Matthew Stone Reeves 19 BIRTHPLACE OF FATHER (City) (State or country) Charleston, South Carolina 20 MAIDEN NAME OF MOTHER Edna Simpson 21 BIRTHPLACE OF MOTHER (City) (State or country) Mineola, Long Island New York	
7 NAME OF FUNERAL DIRECTOR J.S. Waterman & Sons ADDRESS Boston, Massachusetts 8 Informant Mr. Delavan S. Mussey (hus.) (Address) 11 Granvaile Rd., Southboro		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Shepard N. Cohen (Signature of Agent Board of Health or other) Acting Dir. of Public Health 5/2/72 (Official Designation) (Date of Issue of Permit) Received and filed May 2, 1972 A TRUE COPY ATTEST: Paul J. Berry, Town Clerk	



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Grafton

(City or Town making this return)

Worcester

(County)

Grafton

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #21

No. Grafton State Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Lenda Cerutti

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)  
St. Southboro, Mass.  
(City or town and State)

(a) Permanent Residence, No. Worcester Road

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 29, 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from  
10/30/34 to May 29, 1972  
I last saw her alive on May 29, 1972, death is said to  
have occurred on the date stated above, at 8:10 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Thrombosis

(b) Pulmonary Metastasis

(c) Breast cancer

OTHER  
SIGNIFICANT  
CONDITIONS A.S.H.D.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

mo.

1971

years

Was autopsy performed? No

What test confirmed diagnosis? Clin. &amp; Lab.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) M.D.

(Address) 211 Westboro Rd. Date 5/29 1972

6 St. Thacisus Cem. Framingham, Ma.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 31, 1972

7 NAME OF FUNERAL DIRECTOR Lawrence Volpe

ADDRESS Arlington St. Framingham

8 Informant Mrs. Lena Silva

(Address) 62 Centenial Ave. Glocester

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Joseph Cerutti  
(Husband's name in full)13 AGE 79 Years 11 Months 17 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Housewife  
(Kind of work done during most of working life)15 Industry  
or Business

16 Social Security No. 015-16-3092-D

17 BIRTHPLACE (City) Vertigate Varese  
(State or country) Italy

18 NAME OF FATHER not learned

19 BIRTHPLACE OF FATHER (City) not learned  
(State or country) Italy

20 MAIDEN NAME OF MOTHER not learned

21 BIRTHPLACE OF MOTHER (City) not learned  
(State or country) Italy

A TRUE COPY

ATTEST: Raymond P. Jordan  
(Registrar of City or Town where death occurred)

DATE FILED May 30, 1972

Received and filed June 1, June 12, 1972

T. J. Berry  
(Registrar of City or Town where deceased resided)MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

FORM R-302

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)COPY OF  
CERTIFICATE OF DEATH

Registered No. #22

No. Framingham Union Hospital

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME George E. Jackman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR)(a) Permanent Residence, No. 189 Cordaville Rd. St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 5 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from  
7-10 19 49 to 6-5 19 72  
I last saw him alive on 6-5 19 72 death is said to  
have occurred on the date stated above, at 11:05 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary thrombosis

(b) Arteriosclerotic ht. dis.

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro Date 6-6 19 72

6 Rural Cemetery, Southborough  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 8 19 72

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southborough, Mass.8 Informant Robert H. Jackman  
(Address) RFD #3, Storrs, Conn.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR W 11 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN12 If married, widowed, or divorced  
HUSBAND of Denise C. Dagenais  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 90 Years 6 Months 0 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Farmer  
(Kind of work done during most of working life)

15 Industry or Business Farming

16 Social Security No. 030-01-5785

17 BIRTHPLACE (City) Minneapolis  
(State or country) Minn.

18 NAME OF FATHER Hollis W. Jackman

19 BIRTHPLACE OF FATHER (City) Webster  
(State or country) N. H.

20 MAIDEN NAME OF MOTHER Marcia A. Webber

21 BIRTHPLACE OF MOTHER (City) Monroe  
(State or country) Me.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 6-7-72 19

Received and filed June 20 1972 19

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



FORM R-301

Filed for burial permit  
by Board of Health  
or its Agent.

INSTRUCTIONS FOR  
FILLING OUT THIS CERTIFICATE

PRINT OR TYPE  
IN INK OR CAUSE  
OF DEATH  
UNFADING BLACK  
OR APPROVED  
INK TYPEWRITER  
RIBBON

Does not mean the mode of  
such as heart failure, asthe-  
tic. It means the disease, or  
conditions which caused death.  
conditions, if any, which gave  
rise to the above cause (a), stating the  
cause last.

conditions contributing to death  
not related to the terminal dis-  
condition given in (a).

OUT - OF - TOWN

The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)



STANDARD  
CERTIFICATE OF DEATH

Southborough #31

Registered No. 5594

No. New England Medical Center Hosp. St.

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Bessie Korolick  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence. No. 17 Bryden Road St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 6 13 72  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
6-11 19 72 to 6-13 19 72  
I last saw her alive on 6-13 19 72 death is said to  
have occurred on the date stated above, at 9:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure  
Due To  
(b) Ischemic Hypertrophic Subarctic  
Due To  
(c) Probable Coronary Disease

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Phys Exam, chest xray

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Dr. Joan Goldberg M.D.

(Print or Type Name) DR. JOAN GOLDBERG

(Address) NEMC, Et. Date 6/14 19 72

6 Agudas Achim Brockton

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 15, 19 72

7 NAME OF FUNERAL DIRECTOR Morris W. Brezniak

ADDRESS 470 Harvard St. Brookline

8 Informant Samuel Korolick

(Address) 17 Bryden Rd. Southboro

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Samuel Korolick (or) WIFE of (Husband's name in full)

13 AGE 67 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation Housewife (Kind of work done during most of working life)

15 Industry or Business At Home

16 Social Security No.

17 BIRTHPLACE (City) Brockton, Mass. (State or country)

18 NAME OF FATHER Benjamin Fine

19 BIRTHPLACE OF FATHER (City) Russia (State or country)

20 MAIDEN NAME OF MOTHER Rachel Kasef

21 BIRTHPLACE OF MOTHER (City) Russia (State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed JUN 20 1972

19



The Commonwealth of Massachusetts  
 JOHN F. X. DAVOREN  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS  
 COPY OF  
 MEDICAL EXAMINER'S  
 CERTIFICATE OF DEATH

Marlborough

(City or Town making this return)

Registered No. 185

Middlesex

(County)

Marlborough

(City or Town)



Marlboro Hospital

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Walter T. MacDougald

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

(if so specify WAR)

no

#24

15 Meadow Lane

Southborough, Mass.

(a) Permanent Residence. No. St. (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

July 12, 1972

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Head & neck injuries  
 (Driver of vehicle which struck  
 tree.) accident

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 1:30a.m. July 12, 72

IF ACCIDENTAL, was injury causally related to the death? yes

Where did

Injury occur? Marlborough, Mass.

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Public St. While at work? no

(How did injury occur?)

Manner of Auto struck tree

Injury

(Specify type of place)

Nature of head and neck

Injury

Was autopsy performed? no

Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) R. N. Rittenhouse

M. D.

(Address) Marlborough, Mass. Date July 12, 72

6 Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE July 14 1972

7 NAME OF FUNERAL DIRECTOR

Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

8 Informant

Walter MacDougald

(Address) 15 Meadow Lane, Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

Male

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Single

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 19 YEARS 11 MONTHS 10 Days If under 24 hours

14 Usual

Occupation:

Pressman

(Kind of work done during most of working life)

15 Industry

or Business:

Printing

16 Social Security No.

037-32-5814

17 BIRTHPLACE (City)  
(State or country)

Providence, Rhode Island

18 NAME OF FATHER

Walter MacDougald

19 BIRTHPLACE OF FATHER (City)  
(State or country)

Rumford, Rhode Island

20 MAIDEN NAME OF MOTHER

Catherine Nolan

21 BIRTHPLACE OF MOTHER (City)  
(State or country)

Rumford, Rhode Island

A TRUE COPY

ATTEST:

*Peter P. Cottage*  
 (Registrar of City or Town where death occurred)

DATE Agent

July 13, 1972

Received and filed July 19, 1972

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #25

No. Woodside Cottages

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME Bridget Bagley (Sheehan)  
(If deceased is a married, widowed or divorced woman, give also maiden name.){ (If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence, No. Walker

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. 1, 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from  
Jan. 8, 1972, to June 19, 1972, death is said to  
I last saw her alive on June 19, 1972, death is said to  
have occurred on the date stated above, at 6 A.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary heart disease

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
1yr.

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Fractured hip

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Henry Gould, M.D.

(Address) Natick, Mass. Date 8/1 72

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug. 3, 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.8 Informant Joseph R. Bagley, Jr.  
(Address) 34 Townsend Ter., Framingham, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED Widowed  
UNKNOWN12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Joseph R. Bagley, Sr.  
(Husband's name in full)13 AGE 74 Years 2 Months 29 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 034-20-1063

17 BIRTHPLACE (City) Ireland  
(State or country)

18 NAME OF FATHER Michael Sheehan

19 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

20 MAIDEN NAME OF MOTHER Margaret Collins

21 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Aug. 3, 1972

Received and filed August 11, 1972  
Paul J. Berry  
(Registrar of City or Town where deceased resided)MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



FORM R-301

led for burial permit  
Board of Health  
or its Agent.

INSTRUCTIONS FOR  
FILLING OUT THIS CERTIFICATE

PRINT OR TYPE  
NAME OR CAUSES  
OF DEATH  
UNFADING BLACK  
OR APPROVED  
INK TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
c. It means the disease, or  
conditions which caused death.

itions, if any, which gave  
above cause (a), stating the  
ing cause last.

itions contributing to death  
related to the terminal dis-  
condition given in (a).

RECORDS  
TOWN OF SOUTHBOROUGH  
NOV 29 1972  
TOWN CLERKS OFFICE

R-301.150M-3-72-051297

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

6528

No. New England Deaconess Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Mr. Daniel Iandoli  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR) NO

(a) Permanent Residence, No. 6 Walker St.

St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 1, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
June 20, 1972 to August 1, 1972  
I last saw him alive on August 1, 1972, death is said to  
have occurred on the date stated above, at 9:20 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGESTIVE HEART FAILURE

Due To

(b) ARTERIO-SCLEROTIC HEART DISEASE 3 yrs

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis? GROSS FINDINGS

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Peter Gailunas, Jr. M.D.  
PETER GAILUNAS, JR.  
(Print or Type Name)

(Address) WED Date 9/2 1972

6 NEWTON CREMATORY NEWTON, MASS  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 4 AUG 1972

7 NAME OF FUNERAL DIRECTOR Robert P. Norton

ADDRESS 53 Beech ST. FRAMINGHAM

8 Informant MRS. NANCY IANDOLI - wife

(Address) 6 WALKER ST. SOUTH BORO MASS

PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR white 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

12 If married, widowed, or divorced  
HUSBAND of NANCY (CHART) IANDOLI  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 54 Years 5 Months 29 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Chef  
(Kind of work done during most of working life)

15 Industry or Business Industrial Caterer

16 Social Security No. 030-09-2651

17 BIRTHPLACE (City) BOSTON, MASS  
(State or country)

18 NAME OF FATHER GIRO IANDOLI

19 BIRTHPLACE OF FATHER (City) ITALY  
(State or country)

20 MAIDEN NAME OF MOTHER NANCY ASCOLESE

21 BIRTHPLACE OF MOTHER (City) ITALY  
(State or country)

HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
th or BEFORE the burial or transit permit was issued:

7.8 Graca 8/14/684  
(Signature of Agent—Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed AUG 7 1972 19

A TRUE COPY ATTEST: William J. Kane (Registrar)

Nov. 29, 72



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #26

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME William Joseph Cusack III

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 1 Hammond

St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 13 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from June 69, 19 to 8-13-72, 1972.  
I last saw him alive on 8-13-72, death is said to have occurred on the date stated above, at 12:45 p.m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Muscular Dystrophy yrs.

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

Melvin J. Gordon

(Attending Physician) M.D.

(Address) Framingham Date 8-14 72

6 Rural Cemetery Southborough  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southborough, Mass.8 Informant William J. Cusack, Jr.  
(Address) Southborough, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR W 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)13 AGE 16 Years 4 Months 13 Days If under 24 hours  
Hours Minutes14 Usual Occupation Student  
(Kind of work done during most of working life)

15 Industry or Business Schooling

16 Social Security No. none

17 BIRTHPLACE (City) Waltham  
(State or country) Mass.

18 NAME OF FATHER William J. Cusack, Jr.

19 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Alice Fegan

21 BIRTHPLACE OF MOTHER (City) Waltham  
(State or country) Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED 8-14-72

Received and filed September 7, 1972

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Marlborough**  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. **#27**

PLACE OF DEATH

**Middlesex**  
(County)

**Marlborough**  
(City or Town)

No. **Marlboro Hospital**

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
**PHYSICIAN—IMPORTANT**

2 FULL NAME **Lillian (Morin) Charest**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran, **none**  
specify WAR)

(a) Permanent Residence, No. **201 Parkerville Road**

St. **Southborough, Mass.**  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **September 1, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
**January 64**, 19**64**, to **Sept. 1**, 19**72**  
I last saw him alive on **Sept. 1**, 19**72**, death is said to  
have occurred on the date stated above, at **6:15 p** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **arteriosclerotic heart dis. 8 yrs**

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS **Diabetes Mellitus**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**10 yrs**

Was autopsy performed? **no**

What test confirmed diagnosis? **EKG, Clinical, X-ray**

5 Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify

**John Paul Ahearn**  
(Attending Physician) M.D.

(Address) **Marlboro, Mass. Sept. 1, 72**

6 **Rural Cemetery, Southboro, Mass.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Sept. 4**, 19**72**

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**

ADDRESS **40 Main St. Southboro, Mass.**

8 Informant **Maurice C. Charest**

(Address) **3 Gilmore Rd. Southboro, Mass.**

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Female** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED** **Widowed**  
**UNKNOWN**

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of **Charles B. Charest**  
(Husband's name in full)

13 AGE **71** Years **0** Months **11** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **Housewife**  
(Kind of work done during most of working life)

15 Industry or Business **at home**

16 Social Security No. **017 03 8395**

17 BIRTHPLACE (City)  
(State or country) **Hudson, Mass.**

18 NAME OF FATHER **Henry Morin**

19 BIRTHPLACE OF FATHER (City)  
(State or country) **Shrewsbury, Mass.**

20 MAIDEN NAME OF MOTHER **Amelia Brodeur**

21 BIRTHPLACE OF MOTHER (City)  
(State or country) **Magog, Quebec**  
**Canada**

A TRUE COPY **Peter P. Cottone**  
ATTEST: **Peter P. Cottone**  
(Registrar of City or Town where death occurred)

DATE FILED **September 5**, 19**72**

Received and filed **September 7**, 19**72**

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Framingham

(City or Town making this return)

Registered No. #29

No. Framingham Union Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert M. Ansell  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

(if so specify WAR)

No

2 Fay Court

Southboro, Mass.

(a) Permanent Residence. No. St.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 3, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Brain injury

Fractured skull

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 9:45PM 9/3 1972

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did injury occur? Southboro, Mass.

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? 2 Fay Court While at work? no

(How did injury occur?)

Manner of injury Pedestrian hit by train

(Specify type of place)

Nature of injury See above

Was autopsy performed? Yes

Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Antonio A. Matarese, M. D.

(Address) Framingham, Mass. 9/4 1972

6 Rural Cem., Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE Sept. 6, 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

8 Informant Clifford E. Ansell, Sr.

(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 16 YEARS 8 MONTHS 28 Days If under 24 hours Hours Minutes

14 Usual Occupation: Student (Kind of work done during most of working life)

15 Industry or Business Algonquin Regional High

16 Social Security No. 032 44 3329

17 BIRTHPLACE (City) Framingham, Mass. (State or country)

18 NAME OF FATHER Clifford E. Ansell, Sr.

19 BIRTHPLACE OF FATHER (City) Connellsville, Pa. (State or country)

20 MAIDEN NAME OF MOTHER Juanita M. Gross

21 BIRTHPLACE OF MOTHER (City) Quincy, Ill. (State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Sept. 7, 1972

Received and filed September 27, 1972

Paul J. Berry

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON - THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

PLACE OF DEATH

Middlesex  
(County)  
Framingham  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Framingham  
(City or Town making this return)  
Registered No. #30

No. DOA  
Framingham Union Hospital  
St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
2 FULL NAME Claude Bernard MacKinnon  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
PHYSICIAN - IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 17 Rockpoint Rd. St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH September 3, 1972 (Month) (Day) (Year)		9 SEX Male	10 COLOR White
4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.) Brain injury Fractured skull		11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married	
5 Accident, suicide, or homicide (specify) Accident Date and hour of injury About 1:30am 9/3 19 72 IF ACCIDENTAL, was injury causally related to the death? Yes Where did injury occur? Framingham, Mass. (City or town and State) Did injury occur in or about home, on farm, in industrial place, or in public place? Route 9 While at work? No (How did injury occur?) Manner of injury Pedestrian struck by motor vehicle (Specify type of place) Nature of injury See above		12 If married, widowed, or divorced HUSBAND of Kathleen Gaudet (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)	
Was autopsy performed? Yes		13 AGE 31 YEARS 1 MONTHS 15 Days If under 24 hours Hours Minutes	
Was disease or injury in any way related to occupation of deceased? NO If so, specify		14 Usual Occupation Branch mgr.-ass't VP. (Kind of work done during most of working life)	
(Signed) Antonio A. Matarese, M. D. (Address) Framingham, Mass. Date 9/3 19 72		15 Industry or Business First Nat'l Bank of Natick	
6 St. Patrick's Cem., Grand River, PEI. Place of Burial or Cremation (City or Town) DATE Sept. 6, 19 72		16 Social Security No. 021-42-9093	
7 NAME OF FUNERAL DIRECTOR Eugene J. McCarthy & Son ADDRESS Framingham, Mass. Kathleen MacKinnon Southboro, Mass.		17 BIRTHPLACE (City) (State or country) Canada	
8 Informant (Address)		18 NAME OF FATHER Bernard MacKinnon	
		19 BIRTHPLACE OF FATHER (City) (State or country) Canada	
		20 MAIDEN NAME OF MOTHER Ella Morrison	
		21 BIRTHPLACE OF MOTHER (City) (State or country) Canada	
		A TRUE COPY	
		ATTEST: (Registrar of City or Town where death occurred)	
		DATE FILED Sept. 12, 19 72	
		Received and filed September 27 19 72 Paul J. Berry (Registrar of City or Town where death occurred)	



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. #28

1 PLACE OF DEATH  
Worcester  
(County)  
Southborough  
(City or Town)



No. 6 Prentiss

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

### PHYSICIAN-IMPORTANT

2 FULL NAME Jessie Louise (Hyde) Beaton  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) None

(a) Permanent Residence, No. 6 Prentiss

St. Southborough, Mass.  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 7 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from August 3 1968, to September 7, 1972. I last saw her alive on September 7, 1972, death is said to have occurred on the date stated above, at 3:00 p.m.

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Aneurysm, dissecting, thoracic aorta 5 days  
Due To  
(b) Arteriosclerosis yrs  
Due To  
(c)

OTHER SIGNIFICANT CONDITIONS Pneumonia, bronchial, incipient 2 days

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Timothy P. Stone M.D.  
(Print or Type Name) TIMOTHY P. STONE  
(Address) 42 MAIN, SOUTHBORO Date Sept 8 1972

6 Rural Cemetery Southborough, Mass  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL Sept. 9 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS 40 Main Street Southborough

8 Informant Mrs. Eleanor Burke Mass.  
(Address) Woolwich Maine

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR White 11 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Albert Beaton (Husband's name in full)

13 AGE 88 Years 4 Months 13 Days | If under 24 hours Hours Minutes

14 Usual Occupation Housewife (Kind of work done during most of working life)

15 Industry or Business At Home

16 Social Security No. 026-01-0966B

17 BIRTHPLACE (City) Southborough 020-40-0642 (State or country) Mass

18 NAME OF FATHER Edmund A. Hyde

19 BIRTHPLACE OF FATHER (City) Southborough (State or country) Mass

20 MAIDEN NAME OF MOTHER Lizzie Prentiss

21 BIRTHPLACE OF MOTHER (City) Southborough (State or country) Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
Mrs. Sina A. Torcoletti-Agent  
(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit) 9-8-72

Received and filed September 13, 1972

Paul J. Berry, Town Clerk (Registrar)  
A TRUE COPY ATTEST:

RM R-301

led for burial permit  
Board of Health  
or its Agent.

STRUCTIONS FOR  
AL CERTIFICATE

INT OR TYPE  
SE OR CAUSES  
OF DEATH  
UNFADING BLACK  
OR APPROVED  
CK TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
c. It means the disease, or  
ations which caused death.

itions, if any, which gave  
above cause (a), stating the  
ing cause last.

itions contributing to death  
t related to the terminal dis-  
condition given in (a).

OM-10-70-047979



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Marlborough**  
(City or Town making this return)

#32

280

COPY OF  
CERTIFICATE OF DEATH

Registered No. ....

No. **Braemoor Nursing Home**

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME **Florence G. (Joslyn) Hubley**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR)

no

(a) Permanent Residence, No. **131 Southville Road**

St. **Southborough, Mass.**  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **October 22, 1972**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
**Jan. 10, 1969** to **Oct. 22, 1972**  
I last saw her alive on **Oct. 20, 1972**, death is said to  
have occurred on the date stated above, at **2:45 a.m.**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Pneumonia**

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS **cerebral thrombosis**  
**diabetes mellitus**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
**4 das**

Was autopsy performed?

no

What test confirmed diagnosis? **clinical findings**5 Was disease or injury in any way related to occupation of deceased? **no**

If so, specify

**Z. Stanley Taub**

(Attending Physician) ....., M.D.

(Address) **Sudbury, Mass.** Date **Oct. 22, 1972**6 **Rural Cemetery, Southboro, Mass.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **October 24, 1972**7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**ADDRESS **40 Main St. Southboro, Mass.**8 Informant **George A. Hubley**(Address) **Southville Rd. Southboro, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

**Alvah F. Hubley, Sr.**

(Husband's name in full)

13 AGE

79 Years

0 Months

0 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation

**Housewife**

(Kind of work done during most of working life)

15 Industry

or Business

**at home**

16 Social Security No.

**024 20 3300**

17 BIRTHPLACE (City)

(State or country)

**Boston, Mass.**

18 NAME OF

FATHER

**George A. Joslyn**

19 BIRTHPLACE OF

FATHER (City)

**Worcester, Mass.**

(State or country)

20 MAIDEN NAME

OF MOTHER

**Mary McGaw**

21 BIRTHPLACE OF

MOTHER (City)

**Boston, Mass.**

(State or country)

A TRUE COPY

ATTEST:

**Peter P. Cottone**

(Registrar of City or Town where death occurred)

DATE FILED

**Oct. 24, 1972**

19

Received and filed

**October 24**

19

**72****Paul J. Berry,****Town Clerk****10/26/72**

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Wayland

(City or Town making this return)

PLACE OF DEATH

Middlesex  
(County)Wayland  
(City or Town)COPY OF  
CERTIFICATE OF DEATH

Registered No. #37

No. Cochituate Nursing Home

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME Frances J. (Johns) Whidden  
(If deceased is a married, widowed or divorced woman, give also maiden name.){ (If deceased a  
U. S. War Veteran,  
specify WAR) No

(a) Permanent Residence, No. 42 Flagg Road

St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 8, 1972  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from  
May 29, 1971 to Nov. 8, 1972  
I last saw her alive on Oct. 23, 1972 death is said to  
have occurred on the date stated above, at 9:15 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular Accident

Due To  
(b) ArteriosclerosisDue To  
(c) Old fracture of l.  
hip

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Louis N. Rashin, M.D.

(Address) Wayland Date 11/9 1972

6 Evergreen Cem., Brooklyn, N.Y.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 10, 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS 40 Main St., Southborough

8 Informant Mrs. Lois Denman

(Address) 42 Flagg Rd., Southborough

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Charles W. Whidden  
(Husband's name in full)13 AGE 88 Years 2 Months 12 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 083-14-1258D

17 BIRTHPLACE (City) Weymouth, N.S.  
(State or country) Canada

18 NAME OF FATHER Harley Johns

19 BIRTHPLACE OF FATHER (City) Weymouth, N.S.  
(State or country) Canada

20 MAIDEN NAME OF MOTHER Sarah Journey

21 BIRTHPLACE OF MOTHER (City) Weymouth, N.S.  
(State or country) Canada

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED November 13, 1972

Received and filed January 9, 1973

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

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RM R-301

led for burial permit  
Board of Health  
or its Agent.

STRUCTIONS FOR  
AL CERTIFICATE

INT OR TYPE  
SE OR CAUSES  
OF DEATH  
UNFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, as the-  
c. It means the disease, or  
conditions which caused death.

ditions, if any, which gave  
above cause (a), stating the  
ing cause last.

ditions contributing to death  
t related to the terminal dis-  
condition given in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. #33

PLACE OF DEATH

Worcester  
(County)Southborough  
(City or Town)

No. 43 Richards Road

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME Helen O. (Pierce) Killiam  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN-IMPORTANT

(If deceased a  
U. S. War Veteran,  
specify WAR) None

(a) Permanent Residence, No. 43 Richards Road

St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 13, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
March 18, 1950, to Nov. 13, 1972.  
I last saw her alive on Oct 31, 1972, death is said to  
have occurred on the date stated above, at 4:45 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Sudden

(b) Coronary Sclerosis

18 mos.

(c) Arteriosclerosis

14 yrs

OTHER  
SIGNIFICANT  
CONDITIONS Hypertension

14 yrs

Was autopsy performed? no

What test confirmed diagnosis? Recent Hosp. Observation

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Timothy P. Stone, M.D.

TIMOTHY P. STONE

(Print or Type Name)

(Address) 42 Main St., Southboro Date Nov. 14, 1972

6 Rural Cemetery Southborough, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 16, 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street Southborough, Mass.

8 Informant Albert Earl Killiam

43 Richards Road, Southborough, Mass.  
(Address)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR White 11 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Albert Earl Killiam  
(Husband's name in full)13 AGE 72 Years 7 Months 25 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At. Home

16 Social Security No. 022-36-4177

17 BIRTHPLACE (City) Roxbury  
(State or country) Mass.

18 NAME OF FATHER Fulton Pierce

19 BIRTHPLACE OF FATHER (City) Colechester N.S.  
(State or country) Canada

20 MAIDEN NAME OF MOTHER Lillian Johnson

21 BIRTHPLACE OF MOTHER (City) Plymouth County N.S.  
(State or country) CanadaI HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
with me BEFORE the burial or transit permit was issued:

(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed November 20, 1972

A TRUE COPY ATTEST:

(Registrar)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham

(City or Town making this return)

Middlesex

(County)

Framingham

(City or Town)

Kathleen Daniel Nursing Home

No.

COPY OF

CERTIFICATE OF DEATH

Registered No. #36

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

Theresa Sullivan (McLaughlin)

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a

U. S. War Veteran, No

Southboro, Mass.

(a) Permanent Residence, No.

59 Boston Rd.

St.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

November 26, 1972

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended and deceased on  
Nov. 26, 1972  
I last saw her alive on Nov. 25, 1972, death is said to  
have occurred on the date stated above, at 8:00A.M.

DEATH WAS CAUSED BY IMMEDIATE CAUSE  
Arteriosclerotic hypertensive  
cardiac disease

(a)

Due To

Hypertension

(b)

Due To

Nephrosclerosis

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

No

What test confirmed diagnosis?

Physical examination

5 Was disease or injury in any way related to occupation of deceased?

No

If so, specify

Grace E. Tiffany,

(Attending Physician)

M.D.

(Address) Framingham, Mass. Date 11/26 72

6 St. Stephen's Cem., Framingham, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Nov. 29, 72

7 NAME OF

FUNERAL DIRECTOR

Edith E. Cunningham

ADDRESS

Framingham, Mass.

8 Informant

Eileen M. Pernham

(Address)

Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX  
Female10 COLOR  
White11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN  
Widowed12 If married, widowed, or divorced  
HUSBAND of

George E. Sullivan (full)

(or) WIFE of

(Husband's name in full)

13 AGE 79 Years 11 Months 14 Days If under 24 hours  
Hours Minutes14 Usual  
Occupation

Dennison Employee

(Kind of work done during most of working life)

15 Industry  
or Business

Dennison Mfg. Co.

16 Social Security No. 019-10-0534

17 BIRTHPLACE (City)  
(State or country) Framingham, Mass.18 NAME OF  
FATHER Michael McLaughlin19 BIRTHPLACE OF  
FATHER (City)  
(State or country) Ireland20 MAIDEN NAME  
OF MOTHER Mary Carr21 BIRTHPLACE OF  
MOTHER (City)  
(State or country) Ireland

A TRUE COPY

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

Dec. 4, 1972

Received and filed

Paul J. Berry

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



RM R-301

and for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS FOR  
FILLING OUT CERTIFICATE

1. TYPE OR TYPE  
2. OR CAUSES  
3. OF DEATH  
4. FADING BLACK  
5. OR APPROVED  
6. TYPEWRITER  
7. RIBBON

does not mean the mode of  
such as heart failure, asthe-  
It means the disease, or  
conditions which caused death.

tions, if any, which gave  
above cause (a), stating the  
ing cause last.

tions contributing to death  
related to the terminal dis-  
tribution given in (a).

1  
PLACE OF DEATH  
SUFFOLK  
(County)  
BOSTON  
(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

#38

STANDARD  
CERTIFICATE OF DEATH

Registered No. 10077

No. New England Medical Center Hospitals St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN-IMPORTANT

George Pierce

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR)

(a) Permanent Residence, No. 204 Parkerville Road

St. Southboro, Ma (City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 28, 1972  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from November 11, 1972 to November 28, 1972  
I last saw him alive on November 28, 1972, death is said to have occurred on the date stated above, at 5:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac arrest

Due To (b) Congenital Heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS Down's Syndrome

Was autopsy performed? No

What test confirmed diagnosis? Cardiac Catheterization, Angiogram

5 Was disease or injury in any way related to occupation of deceased?

If so, specify No

(Signature) Charles J. Cole M.D.

(Address) 20 Ash St. Boston Date Nov. 28, 1972

RURAL CEMETERY SOUTH BOROUGH  
Place of Burial or Cremation (City or Town) MASS

DATE OF BURIAL NOV 29, 1972

7 NAME OF FUNERAL DIRECTOR DONALD C. MORRIS  
40 MAIN ST SOUTH BOROUGH MASS

8 Informant MRS JEAN PIERCE  
204 PARKERVILLE RD SOUTH BOROUGH MASS

PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR WHITE 11 SINGLE (write the word) SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE Years 2 Months 28 Days If under 24 hours Hours Minutes

14 Usual Occupation INFANT (Kind of work done during most of working life)

15 Industry or Business NONE

16 Social Security No. NONE

17 BIRTHPLACE (City) FRAMINGHAM (State or country) MASS

18 NAME OF FATHER WILLIAM H. PIERCE

19 BIRTHPLACE OF FATHER (City) SO. KINSTON (State or country) R.I.

20 MAIDEN NAME OF MOTHER JEAN WALTERMIRE

21 BIRTHPLACE OF MOTHER (City) NEW HAVEN (State or country) CONN

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent Board of Health or other) 11/28/72

(Official Designation) (Date of Issue of Permit)

Received and filed DEC 1 1972

A TRUE COPY ATTEST: March 6, 73 (Registrar)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Marlborough

(City or Town making this return)

Middlesex

(County)

Marlborough

(City or Town)



COPY OF

#35

318

## CERTIFICATE OF DEATH

Registered No. ....

Braemoor Nursing Home

No. .... St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

Theophilda V. (Cousineau) St. Maurice

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

117 Framingham Rd.

Southborough, Mass.

(a) Permanent Residence, No. .... St. .... (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 28, 1972  
(Month) (Day) (Year)

4 I last saw him alive on Oct. 27, 1972, at 12:15 p.m. death is said to have occurred on the date stated above, at 12:15 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

cerebral thrombosis

(a)

Due To arterial hypertension

(b)

Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

no

Was autopsy performed?

clinical

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

John Paul Ahearn

(Attending Physician) ...., M.D.

Marlboro, Mass. Nov. 28 72

(Address) .... Date .... 19..

6 Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 1 1972

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main St. Southboro, Mass.

ADDRESS Arthur J. St. Maurice

8 Informant 117 Framingham Rd. Southboro,

(Address) .... Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word) MARRIED Widowed WIDOWED Divorced UNKNOWN

12 If married, widowed, or divorced

HUSBAND of Henry A. St. Maurice

(or) WIFE of (Husband's name in full)

13 AGE 84 Years 1 Months 29 Days If under 24 hours Hours Minutes

14 Usual Occupation Housewife

(Kind of work done during most of working life)

15 Industry or Business

025 03 7767 A

16 Social Security No. ....

17 BIRTHPLACE (City) Montreal, Canada

(State or country)

18 NAME OF FATHER Homitas Cousineau

19 BIRTHPLACE OF FATHER (City) Montreal, Canada

(State or country)

20 MAIDEN NAME OF MOTHER Delia Lavigne

21 BIRTHPLACE OF MOTHER (City) Montreal, Canada

(State or country)

A TRUE COPY

Peter P. Cottone

ATTEST: (Registrar of City or Town where death occurred)

Agent Nov. 28, 1972

DATE FILED December 1 1972

Received and filed December 6, 1972

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #1

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Martha Brown (Thompson)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence, No. 17 E. Main

St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 5, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from 12/27/72 to 1/5/73  
I last saw him alive on 12/27/72, death is said to have occurred on the date stated above, at 2 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hodgkin's Disease

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Node biopsy

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Marvin M. Adner, M.D.

(Address) Framingham, Mass. Date 1/5, 1973

6 Rural Cem., Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 8, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

8 Informant Preston C. Brown

(Address) Southboro, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced

HUSBAND of

(or) WIFE of Preston C. Brown  
(Give maiden name of wife in full)  
(Husband's name in full)

13 AGE 79 Years 7 Months 11 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 019-20-5787

17 BIRTHPLACE (City) Hudson, Mass.  
(State or country)

18 NAME OF FATHER Alfred J. Thompson

19 BIRTHPLACE OF FATHER (City) Canada  
(State or country)

20 MAIDEN NAME OF MOTHER Louise Boudreau

21 BIRTHPLACE OF MOTHER (City) Canada  
(State or country)

A TRUE COPY

ATTEST: Michael J. Wood  
Registrar of City or Town where death occurred

DATE FILED 4679 Jan. 8, 1973

Received and filed January 18, 1973

(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

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## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSHarvard  
(City or Town making this return)COPY OF  
CERTIFICATE OF DEATH

Registered No. #5

No. Cutler Army Hospital, Ft Devens, Ma. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME James Edwin Lindsey (If deceased a married, widowed or divorced woman, give also maiden name.)  
(If deceased a U. S. War Veteran, specify WAR) WW II(a) Permanent Residence. No. 15 Walnut St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 12 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from Jan 5 1973 to Jan 12 1973  
I last saw him alive on January 12 1973, death is said to have occurred on the date stated above, at 7:10 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardio respiratory arrest 5 hoursDue To Bilateral cerebrovascular(b) Accident

Due To

(c) Severe generalized ASCVD 1 yrOTHER SIGNIFICANT CONDITIONS infarction 1 yr  
old myocardialWas autopsy performed? YesWhat test confirmed diagnosis? None5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Attending Physician) Diane E. Pepe, Cpt, MC, M.D.(Address) CAH, Ft Devens, Ma. Date Jan 13 19736 Cedar Hill, Baltimore, MD

Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 17 19737 NAME OF FUNERAL DIRECTOR Wadsworth Funeral HomeADDRESS 108 Lincoln St., Framingham, Ma.8 Informant Mrs Mary E. Lindsey(Address) 15 Walnut St., Southboro, Ma.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR CAU 11 SINGLE (write the word)MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN12 If married, widowed, or divorced Mary E. McCarty  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 67 Years 2 Months 20 Days | If under 24 hours  
Hours Minutes14 Usual Occupation Research Assistant  
(Kind of work done during most of working life)15 Industry or Business US Army16 Social Security No. 218-05-057517 BIRTHPLACE (City) Rankin, Pa.  
(State or country)18 NAME OF FATHER James Lindsey19 BIRTHPLACE OF FATHER (City) Pa.  
(State or country)20 MAIDEN NAME OF MOTHER Fanney F. Kaiser21 BIRTHPLACE OF MOTHER (City) Pa.  
(State or country)

## A TRUE COPY

ATTEST: William S. Wood  
(Registrar of City or Town where death occurred)DATE FILED January 22 1973Received and filed February 9, 1973Paul J. Berry  
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



**SPACE FOR ADDITIONAL INFORMATION .....**

**DATE OF ENTERING MILITARY SERVICE** ..... January 1929 .....

**DATE OF DISCHARGE** ..... January 31, 1960 .....

**RANK, RATING** ..... M/SGT.....

**ORGANIZATION AND OUTFIT** ..... Natick Labs, Natick, Ma. ....

**SERVICE NUMBER** ..... RA..6789109.....



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

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1/24/73

The Commonwealth of Massachusetts	
<p style="text-align: center;">Middlesex (County)</p> <p style="text-align: center;">Ashland (City or Town)</p> <p>No. <u>Dugan Rest Home</u></p>	<p style="text-align: center;">JOHN F. X. DAVOREN SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS</p> <p style="text-align: center;">Ashland (City or Town making this return)</p>
<p><b>COPY OF</b> <b>CERTIFICATE OF DEATH</b></p>	
<p>Registered No. <u>#2</u></p>	
<p>(If death occurred in a hospital or institution, give its NAME instead of street and number) <b>PHYSICIAN—IMPORTANT</b></p>	
<p>2 FULL NAME <u>Gino Tomasetti</u> (If deceased is a married, widowed or divorced woman, give also maiden name.)</p>	
<p>(a) Permanent Residence, No. <u>73 Southville Road</u> St. <u>Southboro, Mass.</u> (City or town and State)</p>	
<p><b>MEDICAL CERTIFICATE OF DEATH</b></p>	
<p>3 DATE OF DEATH <u>January 20, 1973</u> (Month) (Day) (Year)</p>	
<p>4 I HEREBY CERTIFY, that I attended deceased from <u>Jan. 15, 1973</u> to <u>Jan. 20, 1973</u> I last saw him alive on <u>Jan. 15, 1973</u>, death is said to have occurred on the date stated above, at <u>11:15 a.m.</u></p>	
<p>DEATH WAS CAUSED BY: IMMEDIATE CAUSE</p>	
<p>(a) <u>Coronary Thrombosis</u></p>	
<p>Due To <u>Atherosclerosis</u> (b) <u>2yrs+</u></p>	
<p>Due To (c)</p>	
<p>OTHER SIGNIFICANT CONDITIONS <u>Diabetes Mellitus date of diagnosis 3wks</u></p>	
<p>Was autopsy performed? <u>No</u> <u>12-29-72</u></p>	
<p>What test confirmed diagnosis? <u>history-hosp. observ.</u> <u>1-16-73</u></p>	
<p>5 Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify _____</p>	
<p>(Attending Physician) <u>Timothy P. Stone, M.D.</u></p>	
<p>(Address) <u>42 Main, Southboro</u> <u>Jan. 21, 73</u> Date _____</p>	
<p>6 <u>Rural Cemetery</u> <u>Southboro, Mass.</u> Place of Burial or Cremation (City or Town)</p>	
<p>DATE OF BURIAL <u>Jan. 22, 1973</u></p>	
<p>7 NAME OF FUNERAL DIRECTOR <u>Donald C. Morris</u> ADDRESS <u>40 Main Street Southboro Mass.</u></p>	
<p>8 Informant <u>Raymond Tomasetti</u> (Address) <u>193 Woodland Rd. Southboro, Mass.</u></p>	
<p><b>PERSONAL AND STATISTICAL PARTICULARS</b></p>	
9 SEX <u>M</u>	10 COLOR <u>White</u>
11 SINGLE (write the word) <u>MARRIED</u> <u>WIDOWED</u> <u>DIVORCED</u> <u>UNKNOWN</u>	
12 If married, widowed, or divorced <u>Pierina Walla</u> HUSBAND of (Give maiden name of wife in full)	
(or) WIFE of (Husband's name in full)	
13 AGE <u>75</u> Years <u>11</u> Months <u>7</u> Days   If under 24 hours Hours _____ Minutes _____	
14 Usual Occupation <u>Railroad worker</u> (Kind of work done during most of working life)	
15 Industry or Business <u>Penn. Central R.R.</u>	
16 Social Security No. <u>714-10-6939</u>	
17 BIRTHPLACE (City) <u>Fano</u> (State or country) <u>Italy</u>	
18 NAME OF FATHER <u>Pacifico Tomasetti</u>	
19 BIRTHPLACE OF FATHER (City) <u>Fano</u> (State or country) <u>Italy</u>	
20 MAIDEN NAME OF MOTHER <u>Palma Brunetti</u>	
21 BIRTHPLACE OF MOTHER (City) <u>Fano</u> (State or country) <u>Italy</u>	
A TRUE COPY	
ATTEST: <u>Silda M. Bernard</u> (Registrar of City or Town where death occurred)	
DATE FILED <u>Jan. 22, 1973</u>	
Received and filed <u>Jan. 24, 1973</u> <u>Taul J. Berry</u> (Registrar of City or Town where deceased resided)	



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-5-61-938000

<p>1 PLACE OF DEATH</p> <p>Middlesex (County)</p> <p>Sudbury (City or Town)</p>		<p>The Commonwealth of Massachusetts</p> <p>KEVIN H. WHITE</p> <p>SECRETARY OF THE COMMONWEALTH</p> <p>DIVISION OF VITAL STATISTICS</p>		<p>Sudbury</p> <p>(City or Town making this return)</p>	
<p>2 FULL NAME</p> <p>Charles Baskerville Saunders</p> <p>(If deceased is a married, widowed or divorced woman, give also maiden name.)</p>		<p>COPY OF</p> <p>CERTIFICATE OF DEATH</p>		<p>Registered No. #3 2</p>	
<p>(a) Permanent Residence. No. 14 Latisquama Road</p> <p>St. Southboro, Mass.</p> <p>(City or town and State)</p>		<p>No. Sudbury Pines Nursing Home</p> <p>St. (If death occurred in a hospital or institution, give its NAME instead of street and number)</p>		<p>(Was deceased a U. S. War Veteran, if so specify WAR) No</p>	
<p>Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.</p>					
<p>MEDICAL CERTIFICATE OF DEATH</p>			<p>PERSONAL AND STATISTICAL PARTICULARS</p>		
<p>3 DATE OF DEATH Jan. 24 1973</p> <p>(Month) (Day) (Year)</p>			<p>8 SEX Male</p>		
<p>4 I HEREBY CERTIFY, That I attended deceased from March 23 19 48 to Jan. 24 19 73</p> <p>I last saw him alive on Jan. 24 19 73, death is said to have occurred on the date stated above, at 12:30p.m.</p>			<p>9 COLOR White</p>		
<p>DEATH WAS CAUSED BY: IMMEDIATE CAUSE</p> <p>(a) Carcinoma, prostate</p>			<p>10 SINGLE (write the word) MARRIED Widowed Married</p>		
<p>Due To (b)</p>			<p>11 If married, widowed, or divorced HUSBAND of Lucy Carmichael</p> <p>(Give maiden name of wife in full)</p>		
<p>Due To (c)</p>			<p>(or) WIFE of (Husband's name in full)</p>		
<p>OTHER SIGNIFICANT CONDITIONS No</p>			<p>12 AGE 81 Years 7 Months 18 Days</p> <p>If under 24 hours Hours Minutes</p>		
<p>Was autopsy performed? No</p> <p>What test confirmed diagnosis? Biopsy, X-ray</p>			<p>13 Usual Occupation: School Teacher - Retired</p> <p>(Kind of work done during most of working life)</p>		
<p>5 Was disease or injury in any way related to occupation of deceased? No</p> <p>If so, specify</p>			<p>14 Industry or Business:</p>		
<p>(Signature) Timothy P. Stone, M. D.</p>			<p>15 Social Security No. 044-18-8285</p>		
<p>(Address) Southboro Date Jan. 24 19 73</p>			<p>16 BIRTHPLACE (City) Solonika, Greece</p> <p>(State or country)</p>		
<p>6 Confederate Cem. Fredericksburg, Va.</p> <p>Place of Burial or Cremation (City or Town)</p>			<p>17 NAME OF FATHER Alexander P. Sauders</p>		
<p>DATE OF BURIAL Jan. 27 1973</p>			<p>18 BIRTHPLACE OF FATHER (City) Cripple Creek</p> <p>(State or country) Virginia</p>		
<p>7 NAME OF FUNERAL DIRECTOR Richard P. Coldwell</p>			<p>19 MAIDEN NAME OF MOTHER Susey Baskerville</p>		
<p>ADDRESS 133 W. Main St., Marlboro, Mass.</p>			<p>20 BIRTHPLACE OF MOTHER (City) Hampden Sydney</p> <p>(State or country) Virginia</p>		
<p>Received and filed February 2 19 73</p> <p>Paul J. Berry</p> <p>(Registrar of City or Town where deceased resided)</p>			<p>21 Informant Mrs. Lucy Saunders</p> <p>(Address) 14 Latisquama Rd., Southboro, Mass.</p>		
<p>A TRUE COPY</p>			<p>ATTEST: Harriet B. Bardecker</p> <p>(Registrar of City or Town where death occurred)</p>		
<p>DATE FILED Jan 25 19 73</p>			<p></p>		



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

2/13/73

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

# 6  
Registered No.

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Alexander H. Gibson  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. 1 Bridge St. Southboro, Mass.  
(If deceased a U. S. War Veteran, specify WAR) None  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 29, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Nov. 7, 1970 to Jan. 29, 1973  
I last saw him alive on Jan. 28, 1973 death is said to have occurred on the date stated above, at 8:30 A.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

Due To (b) Hypertension

Due To (c) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus

Was autopsy performed? No  
What test confirmed diagnosis? In hosp. observation tests

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. 1/30 73  
Date 19

6 Groton Cem., Groton, Vermont  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL Feb. 1, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Mrs. Lorraine Needle  
(Address) St. James Cir., Hudson, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced, HUSBAND of Mabel Lund  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 89 Years 2 Months 8 Days If under 24 hours Hours Minutes

14 Usual Occupation Farmer  
(Kind of work done during most of working life)

15 Industry or Business Retired

16 Social Security No. 003-24-3866

17 BIRTHPLACE (City) Peacham, Vt.  
(State or country)

18 NAME OF FATHER Oscar J. Gibson

19 BIRTHPLACE OF FATHER (City) Barnet, Vt.  
(State or country)

20 MAIDEN NAME OF MOTHER Nancy E. Dunn

21 BIRTHPLACE OF MOTHER (City) Groton, Vt.  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Feb. 1, 1973

Received and filed Feb. 13 73

(Registrar of City or Town where deceased resided)



iled for burial permit  
Board of Health  
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B. - WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 40, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-70-047760

1

PLACE OF DEATH

Worcester

(County)

Southborough

(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. #4

No. 9 Lovers Lane

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Robert E.

(First Name)

Coleman

(Middle Name)

Coleman

(Last Name)

PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR) None

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 9 Lovers Lane

St. Southborough, Mass.

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

Feb.

2

(Day)

1973

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes: Heart disease, pre-  
sumably myocardial infarction  
(Sudden Death)

5 Accident, suicide, or homicide (specify)

Date and hour of injury ..... 19

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? While at work?

(How did injury occur?)

Manner of

Injury

(Specify type of place)

Nature of

Injury

Was autopsy performed? NO

Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)

S. Alden Guild

M. D.

(Address)

S. Alden Guild M.D.

(Print or Type Name)

Date Feb 2 1973

6 Rural Cemetery Southborough, Mass

Place of Burial or Cremation

(City or Town)

DATE Feb 5

1973

7 NAME OF

Donald C. Morris

FURNERAL DIRECTOR

ADDRESS

40 Main Street Southborough, Mass

8 Informant

Mrs. Frances J. Coleman

(Address)

9 Lovers Lane Southborough, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

M

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Married

12 If married, widowed, or divorced

HUSBAND of

Frances J. Mingin

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 62 YEARS 6 MONTHS 19 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Service Mgr.

(Kind of work done during most of working life)

15 Industry

or Business:

Jet Spray Supply

16 Social Security No.

025-03-1812

17 BIRTHPLACE (City)

Boston

(State or country)

Mass.

18 NAME OF

FATHER

John R. Coleman

19 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Mass.

20 MAIDEN NAME

OF MOTHER

Elizabeth Flannery

21 BIRTHPLACE OF

MOTHER (City)

Boston

(State or country)

Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Coleman Agent

(Signature of Agent Board of Health or other)

(Official Designation)

February 7, 1973

Received and filed

Paul J. Berry

19

A TRUE COPY ATTEST:

(Registrar)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham

(City or Town making this return)

Middlesex

(County)

Framingham

(City or Town)

PLACE OF DEATH

COPY OF  
CERTIFICATE OF DEATH

Registered No. #7

No. Cushing Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Mary A. Silvestri (D'Ostillo)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence, No. 64 Flagg Rd.

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 2, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Jan. 19, 1972, to Feb. 2, 1973  
I last saw her alive on Feb. 2, 1973, death is said to  
have occurred on the date stated above, at 7:05 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory failure

Due To Chronic lung disease  
(b)

Due To Atelectasis &  
bronchopneumonia  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS Cerebral arteriosclerosis  
Pulmonary embolism

Was autopsy performed? NO

What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Attending Physician) Kitkasame Khongtrakul, M.D.

Cushing Hospital

(Address) Framingham, Mass. Date 2/2, 1973

6 St. Luke's Cem., Westboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 5, 1973

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

8 Informant Medical Records  
(Address) Cushing Hosp., Framingham, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Paul Silvestri  
(Husband's name in full)

13 AGE 88 Years 1 Months 25 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business Own home

16 Social Security No. 013-18-4109 D

17 BIRTHPLACE (City) Italy  
(State or country)

18 NAME OF FATHER Francis D'Ostillo

19 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

20 MAIDEN NAME OF MOTHER Domenica CNBL

21 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

A TRUE COPY

ATTEST (Registrar of City or Town where death occurred)

DATE FILED Feb. 6, 1973

Received and filed FEB 13 73

(Registrar of City or Town where deceased resided)



FORM R-303

To be filed for burial permit with Board of Health or its Agent.

NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-72-051297

1 PLACE OF DEATH  
 Worcester (County)  
 Southboro (City or Town)



The Commonwealth of Massachusetts  
 JOHN F. X. DAVOREN  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
 CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. #8

No. 8 MAIN St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 2 FULL NAME Edmund H. BULLARD  
 (First Name) (Middle Name) (Last Name)  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)  
 PHYSICIAN — IMPORTANT  
 (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No. 8 MAIN St. Southboro, MASS.  
 (City or town and State)

MEDICAL CERTIFICATE OF DEATH  
 3 DATE OF DEATH Feb. 9 1973  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
 Natural causes: Heart disease  
 Presumably coronary occlusion  
 (Found dead in bed)

5 Accident, suicide, or homicide (specify) \_\_\_\_\_  
 Date and hour of injury \_\_\_\_\_ 19\_\_\_\_  
 IF ACCIDENTAL, was injury causally related to the death? \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town and State)  
 Did injury occur in or about home, on farm, in industrial place, or in public place? \_\_\_\_\_ While at work? \_\_\_\_\_  
 (Specify type of place)  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 (How did injury occur?)  
 Was autopsy performed? NO  
 Was disease or injury in any way related to occupation of deceased? NO  
 If so, specify \_\_\_\_\_  
 (Signed) S. Alden Guild M.D.  
 (Address) Gray St. (Print or Type Name) Date Feb 9 1973

6 RURAL Cemetery Crematory, Worcester  
 Place of Burial or Cremation (City or Town)  
 DATE Feb 11 1973

7 NAME OF FUNERAL DIRECTOR John P. Rowe  
 ADDRESS 57 Main St. Marlboro, MASS.

8 Informant Mrs. Edmund Bullard (wife)  
 (Address) 8 Main St. Southboro, MASS.

PERSONAL AND STATISTICAL PARTICULARS  
 9 SEX MALE 10 COLOR white 11 SINGLE (write the word) MARRIED  
 12 If married, widowed, or divorced HUSBAND of Mary L. Draper  
 (Give maiden name of wife in full)  
 (or) WIFE of \_\_\_\_\_  
 (Husband's name in full)  
 13 AGE 68 Years 7 Months 22 Days If under 24 hours \_\_\_\_\_ Hours \_\_\_\_\_ Minutes  
 14 Usual Occupation: Retired-Sales Manager  
 (Kind of work done during most of working life)  
 15 Industry or Business: MANUFACTURER  
 16 Social Security No. 022-09-5046  
 17 BIRTHPLACE (City) Medfield MASS  
 (State or country)  
 18 NAME OF FATHER George Bullard  
 19 BIRTHPLACE OF FATHER (City) Medfield MASS  
 (State or country)  
 20 MAIDEN NAME OF MOTHER Iva Bailey  
 21 BIRTHPLACE OF MOTHER (City) Medfield MASS  
 (State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
 Mrs. Sina A. Torcollette - Agent  
 (Signature of Agent Board of Health or other)  
 2-10-73  
 (Official Designation) (Date of Issue of Permit)

Received and filed FEB 13 1973  
 Paul J. Berry (Registrar)  
 A TRUE COPY ATTEST:







RM R-301

For burial permit  
Board of Health  
Agent.

INSTRUCTIONS FOR  
FILLING OUT CERTIFICATE

PRINT OR TYPE  
NAME OR CAUSES  
OF DEATH  
FADING BLACK  
OR APPROVED  
TYPEWRITER  
RIBBON

Does not mean the mode of  
death as heart failure, asthma,  
It means the disease, or  
conditions which caused death.

Conditions, if any, which gave  
rise to the disease, or  
cause last.

Conditions contributing to death  
related to the terminal  
disease given in (a).

Suppl. Filed 5/2/73.

# OUT-OF-TOWN

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No.

#12  
1856

No. NEW ENGLAND MEDICAL CENTER HOSPITALS

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN-IMPORTANT

2 FULL NAME

John Sargent

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No.

30 Walnut

Dr.

St.

Southboro

Mass

(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH

Feb.

27

1973

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from  
Feb. 21, 1973 to Feb. 27, 1973.  
I last saw him alive on Feb. 27, 1973, death is said to  
have occurred on the date stated above, at 8:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC ARREST

Due To

(b) AORTIC ARCH ATRESIA

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS.

RENAL FAILURE

Was autopsy performed?

NO

What test confirmed diagnosis?

SURGERY

5 Was disease or injury in any way related to occupation of deceased?

NO

If so, specify

(Signature)

Timothy J. Lepore

M.D.

(Print or Type Name)

(Address)

N.E.M.C.

Date

2/28/73

Place of Burial or Cremation

Feb. 28

(City or Town)

DATE OF BURIAL

1973

7 NAME OF

FUNERAL DIRECTOR

Frank F. Edwards

ADDRESS

94 Congress St. Milford

8 Informant

John W. Sargent Jr.

(Address)

30 Walnut Dr. Southboro

Mass

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX

male

10 COLOR

white

11 SINGLE

(write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

single

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE

Years

Months

Days

If under 24 hours

Hours

Minutes

14 Usual

Occupation

None

(Kind of work done during most of working life)

15 Industry

or Business

none

16 Social Security No.

none

17 BIRTHPLACE (City)

(State or country)

Franklin, Mass

18 NAME OF

FATHER

John W. Sargent Jr.

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Houston

maine

20 MAIDEN NAME

OF MOTHER

Phyllis M. de Luca

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

milford

mass

HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
with me BEFORE the burial or transit permit was issued:

John W. Sargent Jr.

(Signature of Agent-Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

Received and filed

MAR 2 1973

19

A TRUE COPY ATTEST

(Registrar)







# The Commonwealth of Massachusetts

FORM R-302

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Northborough  
(City or Town making this return)

# 13

23

## COPY OF CERTIFICATE OF DEATH

Registered No. ....

No. Thornton Nursing Home St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME William G. Binder, Sr. (If deceased a U. S. War Veteran, specify WAR) none  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. 18 East Main Street St. Southboro, Mass.  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from Feb. 6 1971, to Apr. 4 1973.  
I last saw him alive on Mar. 29 1973, death is said to have occurred on the date stated above, at 12:25 P. M.

#### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral thrombus 2 wk. s

Due To (b) Cerebrat Arteriosclerosis 2 yrs.

Due To (c) Rheumatoid arthritis 10 yrs.

OTHER SIGNIFICANT CONDITIONS (treated) Respiratory illness 1 wk.

Was autopsy performed? no

What test confirmed diagnosis? clinical course

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Attending Physician) Fred M. Pierce, Jr., M.D.

(Address) Northborough, Ma. Date April 4, 73

6 Rural Cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 7 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS 40 Main St. Southboro, Ma.

8 Informant William G. Binder, Jr.  
(Address) 10 E. Main St. Southboro, Ma.

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) Widowed  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed or divorced HUSBAND of Elizabeth G. Richards  
(Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

13 AGE 91 Years 7 Months 29 Days | If under 24 hours  
..... Hours ..... Minutes

14 Usual Occupation Rodeo Performer  
(Kind of work done during most of working life)

15 Industry or Business Retired

16 Social Security No. 526-16-0473

17 BIRTHPLACE (City) Pottstown  
(State or country) Penna.

18 NAME OF FATHER Aaron Binder

19 BIRTHPLACE OF FATHER (City) Pottstown  
(State or country) Penna.

20 MAIDEN NAME OF MOTHER Melinda Everly

21 BIRTHPLACE OF MOTHER (City) CNBL  
(State or country) Ohio

A TRUE COPY

ATTEST: Janice R. Barrows  
(Registrar of City or Town where death occurred)

DATE FILED April 6 1973

Received and filed May 3 1973

(Registrar of City or Town where deceased resided)  
John J. Berry, Town Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



filed for burial permit  
in Board of Health  
or its Agent.

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M1-9-70-047760

1

PLACE OF DEATH

Worcester  
(County)

Southboro  
(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Southborough  
(City or Town making this return)

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Registered No. #11

No. St. Mark's School

{ If death occurred in a hospital or institution,  
give its NAME instead of street and number }

2 FULL NAME

Timothy

Whistler

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

(if so specify WAR)

None

(a) Permanent Residence. No.

Haven Street

St.

Dover, Mass.

(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

April  
(Month)

13  
(Day)

1973  
(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation by suspension, suicidal

5 Accident, suicide, or homicide (specify)

Suicide

Date and hour of injury 9:30 PM 13 Apr 19 73

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? While at work?

Manner of

Injury

(Specify type of place)

Nature of

Injury

Was autopsy performed? NO

Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)

S. Aiden Guire

M. D.

S. Aiden Guire M.D.

(Address)

Grafton

Date

Apr 14 19 73

6 Highland Cemetery Dover, Mass.  
Place of Burial or Cremation (City or Town)

DATE

April 16, 1973

7 NAME OF FUNERAL DIRECTOR

Donald C. Morris

ADDRESS

40 Main St. Southboro, Mass.

8 Informant

Ross Whistler

(Address)

Haven St. Dover, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE

(write the word)

M

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

Single

12 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE

15 YEARS 2 MONTHS 12 Days

If under 24 hours

Hours Minutes

14 Usual Occupation:

Student

(Kind of work done during most of working life)

15 Industry or Business:

St. Mark's School

16 Social Security No.

Boston

17 BIRTHPLACE (City)

Mass.

(State or country)

18 NAME OF FATHER

Ross Whistler

19 BIRTHPLACE OF FATHER (City)

Boston

(State or country)

Mass.

20 MAIDEN NAME OF MOTHER

Vera Potter

21 BIRTHPLACE OF MOTHER (City)

Boston

(State or country)

Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. S. A. Toralenti Agent  
(Signature of Agent Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

Received and filed

April 17, 1973

1973

A TRUE COPY ATTEST:

Paul J. Berry, Town Clerk (Registrar)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Wrentham

(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #14

No. Wrentham State School H-2819 St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME Patricia L. McClard { (If deceased a U. S. War Veteran, specify WAR)

(a) Permanent Residence. No. 252 Parkerville Road St. Southville, Mass. 01774 (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from April 4, 1971, to April 20, 1973.  
I last saw her alive on April 20, 1973, death is said to have occurred on the date stated above, at 8:15 A.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Edema

Due To

(b) Pneumonitis

Due To

(c) Uremia

OTHER SIGNIFICANT CONDITIONS Arnold-Chiari Malformation

INTERVAL BETWEEN ONSET AND DEATH

hours

weeks

months

life

Was autopsy performed? yes

What test confirmed diagnosis? Clinical &amp; Autopsy

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Attending Physician) Yun-Hwa Yu, M.D.

(Address) Wrentham, Mass. Date April 26, 1973

6 Wrentham State School, Wrentham, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24, 1973

7 NAME OF FUNERAL DIRECTOR Walter G. Jackson

ADDRESS Main Street, Franklin, Mass.

8 Informant Records of Wrentham State School

(Address) Wrentham, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR W 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN single

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 10 Years 9 Months 13 Days | If under 24 hours Hours Minutes

14 Usual Occupation Resident of Wrentham State School (Kind of work done during most of working life)

15 Industry or Business None

16 Social Security No. None

17 BIRTHPLACE (City) Framingham (State or country) Mass.

18 NAME OF FATHER Durward E. McClard

19 BIRTHPLACE OF FATHER (City) Missouri (State or country)

20 MAIDEN NAME OF MOTHER Ann B. Cummings

21 BIRTHPLACE OF MOTHER (City) Westboro (State or country) Mass.

A TRUE COPY

ATTEST: George Perry (Registrar of City or Town where death occurred)

DATE FILED April 30, 1973

Received and filed May 8, 1973

(Registrar of City or Town where death occurred) Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



#1042

I R-301

for burial permit  
rd of Health  
Agent.

CTIONS FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH  
ADING BLACK  
APPROVED  
PEWRIER  
3BON

not mean the mode of  
as heart failure, as the  
means the disease, or  
which caused death.  
if any, which gave  
cause (a), stating the  
cause last.

contributing to death  
ed to the terminal dis-  
n given in (a).

2/17/73

70-047979

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WORCESTER

(City or Town making this return)

1 PLACE OF DEATH  
Worcester  
(County)  
Worcester  
(City or Town)



STANDARD  
CERTIFICATE OF DEATH

#17  
Registered No. 1060

No. Worcester City Hospital H2125 St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

## PHYSICIAN-IMPORTANT

2 FULL NAME Margaret T. (McColligan) Fuller  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Permanent Residence. No. 8 Cherry Street St. Southboro, Mass.  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH	APRIL 25, 1973 (Month) (Day) (Year)	9 SEX	10 COLOR
		M	White
4 I HEREBY CERTIFY, that I attended deceased from MARCH 1973 APRIL 25, 1973 I last saw him alive on APRIL 25, 1973, death is said to have occurred on the date stated above, at 7:10 P.M.		11 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERCALCEMIA Due To (b) RENAL CELL CARCINOMA Due To (c) OTHER SIGNIFICANT CONDITIONS		12 If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Fuller (Give maiden name of wife in full) (Husband's name in full)	
INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS		13 AGE 68 Years 7 Months 8 Days   If under 24 hours Hours Minutes	
Was autopsy performed? NO		14 Usual Occupation Housewife (Kind of work done during most of working life)	
What test confirmed diagnosis? SURGERY		15 Industry or Business At Home	
5 Was disease or injury in any way related to occupation of deceased? NO If so, specify		16 Social Security No. 019-18-7370	
(Signature) [Signature] M.D. (Print or Type Name) (Address) 7 BELLEVUE F. Date APRIL 26 1973		17 BIRTHPLACE (City) Ashland (State or country) Mass.	
6 Rural Cemetery Southboro, Mass. Place of Burial or Cremation (City or Town) DATE OF BURIAL April 28, 1973		18 NAME OF FATHER Bernard McColligan	
7 NAME OF FUNERAL DIRECTOR Donald C. Morris 40 Main St. Southboro, Mass. ADDRESS		19 BIRTHPLACE OF FATHER (City) Dublin (State or country) Ireland	
8 Informant Mrs. Margaret Rossi (Address) 8 Cherry Street, Southboro, Mass.		20 MAIDEN NAME OF MOTHER Esther Healy	
		21 BIRTHPLACE OF MOTHER (City) Dublin (State or country) Ireland	
		I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued. (Signature of Agent Board of Health or other) [Signature] (Official Designation) Commissioner of Public Health	
		Received and filed APR 27 1973 Robert J. O'Keefe (Registrar)	
		A TRUE COPY ATTEST:	

216



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)Middlesex  
(County)Framingham  
(City or Town)COPY OF  
CERTIFICATE OF DEATH

Registered No. #15

No. Kathleen Daniel Nursing Home St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME Louis A. Perricotti  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence, No. 7 Newton St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 5, 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from Apr. 15, 1948, to May 5, 1973.  
I last saw him live on Apr. 27, 1973, death is said to have occurred on the date stated above, at 2:40a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Rheumatic heart disease

Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Prior hospital study

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 5/6 73

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 8, 73

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.8 Informant Mrs. Louis Perricotti  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED Widowed WIDOWED Divorced DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of Mildred Bates  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 74 Years 5 Months 22 Days | If under 24 hours Hours Minutes

14 Usual Occupation Meat packer-retired  
(Kind of work done during most of working life)

15 Industry or Business Deerfoot Farms

16 Social Security No. 011-09-7293

17 BIRTHPLACE (City) Boston, Mass.  
(State or country)

18 NAME OF FATHER Fortune Perricotti

19 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

20 MAIDEN NAME OF MOTHER Sarah Bonugli

21 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED May 8, 1973

Received and filed May 14, 1973

(Registrar of City or Town where death occurred)  
Paul J. Berry Town Clerk



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

1 PLACE OF DEATH

Worcester  
(County)

Southboro  
(City or Town)



## STANDARD CERTIFICATE OF DEATH

#16  
Registered No.

No. 120 Northboro Road

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

### PHYSICIAN—IMPORTANT

2 FULL NAME Doris L. (Drake) Johnson  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR) None

(a) Permanent Residence, No. 120 Northboro Road

St. Southboro Mass.  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 13 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Sept 7, 1962, to Oct 9, 1962.  
I last saw her alive on Oct 9, 1962, death is said to  
have occurred on the date stated above, at 5:10 P.M.

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Pyelonephritis

(c) -

OTHER  
SIGNIFICANT  
CONDITIONS no

Was autopsy performed? no

What test confirmed diagnosis? On dialysis for 2 yrs.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify -

(Signature) Timothy P. Stone M.D.

TIMOTHY P. STONE

(Print or Type Name)

(Address) 42 Main St., Southboro Date May 14, 1973

6 Rural Cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 16, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
40 Main Street Southboro Mass.  
ADDRESS

8 Informant Sereno W. Johnson  
120 Northboro Rd. Southboro, Mass.  
(Address)

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR White 11 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Sereno W. Johnson  
(Husband's name in full)

13 AGE 61 Years 4 Months 19 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At Home

16 Social Security No. None

17 BIRTHPLACE (City) Stoughton  
(State or country) Mass.

18 NAME OF FATHER Henry Drake

19 BIRTHPLACE OF FATHER (City) Stoughton  
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Florence Clapp

21 BIRTHPLACE OF MOTHER (City) Stoughton  
(State or country) Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
with me BEFORE the burial or transit permit was issued:

Miss Susan A. Mallett Agent  
(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed May 17, 1973

Paul J. Berry, Registrar

A TRUE COPY ATTEST: Town Clerk

RM R-301

Board of Health  
its Agent.

INSTRUCTIONS FOR  
L CERTIFICATE

NT OR TYPE  
E OR CAUSES  
OF DEATH  
NFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
It means the disease, or  
tions which caused death.

ions, if any, which gave  
bove cause (a), stating the  
g cause last.

ions contributing to death  
related to the terminal dis-  
tition given in (a).



Middlesex

(County)

Marlborough

(City or Town)



The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Marlborough

(City or Town making this return) #19

131

Registered No. ....

Marlboro Hospital

No. .... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John H. Maley, Sr.

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a

W.W. I

U. S. War Veteran,  
(if so specify WAR)

11 Winchester

Southborough, Mass.

(a) Permanent Residence. No. .... St. .... (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 14, 1973

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

heart disease, presumably

coronary sclerosis

sudden death

none

5 Accident, suicide, or homicide (specify) none

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did

Injury occur? .....

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in

public place? ..... While at work? .....

(How did injury occur?)

Manner of

Injury .....

(Specify type of place)

Nature of

Injury .....

no

Was autopsy performed? .....

Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) R. N. Rittenhouse, M. D.

(Address) Marlboro, Mass. May 14, 1973

6 Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation May 17 (City or Town)

DATE May 17, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

John H. Maley, Jr.

8 Informant 8 Winchester St. Southboro, Mass.

(Address)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word)
Male	White	MARRIED WIDOWED DIVORCED UNKNOWN
		Widowed

12 If married, widowed, or divorced Elizabeth Byrne

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE	80	9	15	If under 24 hours
YEARS		MONTHS	Days	Hours Minutes

14 Usual Occupation: Custodian - retired  
(Kind of work done during most of working life)

15 Industry or Business: St. Marks School

16 Social Security No. 018 26 4782

17 BIRTHPLACE (City) Southborough, Mass.  
(State or country)

18 NAME OF FATHER Michael R. Maley

19 BIRTHPLACE OF FATHER (City) Southborough, Mass.  
(State or country)

20 MAIDEN NAME OF MOTHER Johanna Brenn

21 BIRTHPLACE OF MOTHER (City) Westborough, Mass.  
(State or country)A TRUE COPY  
ATTEST: Peter P. Cottone  
(Registrar of City or Town where death occurred)

DATE Agent May 15, 1973

Received and filed MAY XIX June 12, 1973  
Paul J. Berry(Registrar of City or Town where deceased resided)  
Paul J. Berry, Town Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... May 14, 1917 .....

DATE OF DISCHARGE ..... July 7, 1921 .....

RANK, RATING ..... Petty Officer 1st Class .....

ORGANIZATION AND OUTFIT ..... U. S. Navy .....

SERVICE NUMBER ..... 1414258 .....

.....

.....



1269

M R-301

for burial permit  
Board of Health  
its Agent.

ACTIONS FOR  
CERTIFICATE

T OR TYPE  
OR CAUSES  
OF DEATH  
FADING BLACK  
R APPROVED  
TYPEWRITER  
RIBBON

es not mean the mode of  
h as heart failure, as the-  
It means the disease, or  
ions which caused death.

ons, if any, which gave  
ove cause (a), stating the  
r cause last.

ons contributing to death  
elated to the terminal dis-  
tion given in (a).

The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WORCESTER  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

#21  
1282  
Registered No.

No. THE MEMORIAL HOSPITAL #2124 St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME ANNA HOAGLAND (PLUMMER)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR) N.O.  
St. SOUTHBORO, MASSACHUSETTS  
(City or town and State)

(a) Permanent Residence. No. 135 DEERFOOT ROAD

MEDICAL CERTIFICATE OF DEATH	
3 DATE OF DEATH <u>MAY 23 1973</u> (Month) (Day) (Year)	
4 I HEREBY CERTIFY, that <u>ANNA HOAGLAND</u> attended deceased from <u>MAY 23 1973</u> to <u>MAY 23 1973</u> I last saw her alive on <u>MAY 23 1973</u> Death is said to have occurred on the date stated above, at <u>8:10 PM</u>	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Cor pulmonale</u>	
Due To (b) <u>emphysema</u>	<u>yes</u>
Due To (c) <u>—</u>	
OTHER SIGNIFICANT CONDITIONS <u>Psoriaris</u>	<u>yes</u>
Was autopsy performed? <u>yes</u>	
What test confirmed diagnosis? <u>as above</u>	
5 Was disease or injury in any way related to occupation of deceased? If so, specify <u>—</u>	
(Signature) <u>Peter Probst M.D.</u> M.D. (Print or Type Name) (Address) <u>Memorial Hospital</u> Date <u>MAY 24 1973</u>	
6 <u>Rural Crematory</u> <u>Worcester</u> Place of Burial or Cremation (City or Town)	
DATE OF BURIAL <u>MAY 25 1973</u>	
7 NAME OF FUNERAL DIRECTOR <u>GEO. SESSIONS</u> ADDRESS <u>71 Pleasant St - Worcester, Mass</u>	
8 Informant <u>HUDSON HOAGLAND</u> (Address) <u>135 DEERFOOT Rd</u> <u>SOUTHBORO, MASS.</u>	

PERSONAL AND STATISTICAL PARTICULARS		
9 SEX <u>Female</u>	10 COLOR <u>WHITE</u>	11 SINGLE (write the word) <u>MARRIED</u> <u>WIDOWED</u> <u>DIVORCED</u> <u>UNKNOWN</u>
12 If married, widowed, or divorced HUSBAND of <u>ANDREW HOAGLAND</u> (Give maiden name of wife in full) (or) WIFE of <u>—</u> (Husband's name in full)		
13 AGE <u>76</u> Years <u>7</u> Months <u>5</u> Days   If under 24 hours Hours Minutes		
14 Usual Occupation <u>AT HOME</u> (Kind of work done during most of working life)		
15 Industry or Business <u>AT HOME</u>		
16 Social Security No. <u>—</u>		
17 BIRTHPLACE (City) <u>HOWLAND</u> (State or country) <u>MISSISSIPPI</u>		
PARENTS	18 NAME OF FATHER <u>HAZEN MITCHELL PLUMMER</u>	
	19 BIRTHPLACE OF FATHER (City) <u>BANGOR</u> (State or country) <u>MAINE</u>	
	20 MAIDEN NAME OF MOTHER <u>MARY AGNES LADD</u>	
	21 BIRTHPLACE OF MOTHER (City) <u>BANGOR</u> (State or country) <u>MAINE</u>	
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transfer permit was issued <u>Charles J. Smith M.D.</u> (Signature of Agent, Board of Health or other) <u>E.J.</u> <u>25 MAY 73</u> (Official Designation) Commissioner of Public Health		
Received and filed <u>MAY 30 1973</u> <u>Robert J. O'Keefe</u> 19 <u>73</u> (Registrar)		
A TRUE COPY ATTEST:		



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF

#18

## CERTIFICATE OF DEATH

Registered No. ....

Middlesex  
(County)

Framingham  
(City or Town)

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Victor Rossi  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR) None

(a) Permanent Residence, No. 146 Boston Road St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 27, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
March 1, 1973, to May 27, 1973.  
I last saw him alive on May 26, 1973, death is said to  
have occurred on the date stated above, at 8 P. M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CVA (probably hemorrhage)

Due To (b) Hypertension

Due To (c)

OTHER SIGNIFICANT CONDITIONS Severe hypertension

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Attending Physician) William M. Carleton, M.D.

(Address) Southboro, Mass. Date 5/27, 1973

6 Rural Cem., Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 30, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

8 Informant Mrs. Avis Rossi  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED Married  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced HUSBAND of Avis Baker  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 74 Years 1 Months 6 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Groundsman  
(Kind of work done during most of working life)

15 Industry or Business St. Mark's School

16 Social Security No. 019-26-6355 A

17 BIRTHPLACE (City) Italy  
(State or country)

18 NAME OF FATHER Peter Rossi

19 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

20 MAIDEN NAME OF MOTHER Angela Malchiodi

21 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

A TRUE COPY

ATTEST: *Richard J. Wood*  
(Registrar of City or Town where death occurred)

DATE FILED June 5, 1973

Received and filed June 7, 1973

(Registrar of City or Town where deceased resided)  
Paul J. Berry, Town Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in which the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Marlborough

(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #20 152

Middlesex

(County)

Marlborough

(City or Town)

Braemoor Nursing Home

No. \_\_\_\_\_ St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

Donald J. Cocker

2 FULL NAME \_\_\_\_\_  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

10 Brook Lane

(a) Permanent Residence, No. \_\_\_\_\_ St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 5, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from March 23 1973 to June 3 1973  
I last saw him alive on June 3 1973, death is said to have occurred on the date stated above, at 3:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic carcinoma

(b) Primary left lung  
undifferentiated ca

(c)  
OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no  
usual

What test confirmed diagnosis? no

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_

Domenic S. Fiorentino

(Attending Physician) \_\_\_\_\_, M.D.

Marlboro, Mass. June 5 73  
(Address) \_\_\_\_\_ Date \_\_\_\_\_ 1973

Rural Cemetery, Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 9 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Edward Cocker

8 Informant 125 Warren Ave. Marlboro, Mass.

(Address) \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single

12 If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(Give maiden name of wife in full)

(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

13 AGE 50 0 16 Years Months Days If under 24 hours  
Hours Minutes

14 Usual Occupation Commercial Artist  
(Kind of work done during most of working life)

15 Industry or Business Worcester Engraving Co.

16 Social Security No. 028 16 4555

17 BIRTHPLACE (City) Framingham, Mass.  
(State or country)

18 NAME OF FATHER John J. Cocker

19 BIRTHPLACE OF FATHER (City) England  
(State or country)

20 MAIDEN NAME OF MOTHER Rose Mitchell

21 BIRTHPLACE OF MOTHER (City) Boston, Mass.  
(State or country)

A TRUE COPY Peter P. Cottone  
Agent (Registrar of City or Town where death occurred)

ATTEST: June 6, 1973

DATE FILED June 12 1973

Received and filed June 12 1973

Paul J. Berry, Town Clerk

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



**SPACE FOR ADDITIONAL INFORMATION .....**

**DATE OF ENTERING MILITARY SERVICE ..... Feb. 2, 1943**

**Jan. 6, 1946**

**DATE OF DISCHARGE ..... T/5**

**RANK, RATING ..... Co. B. 594th Engr. Boat & Shore Reg.**

**ORGANIZATION AND OUTFIT ..... 31. 259. 368.**

**SERVICE NUMBER .....**

.....



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

Marlborough

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

#22  
180COPY OF  
CERTIFICATE OF DEATH

Registered No. ....

PLACE OF DEATH

Middlesex

(County)

Marlborough

(City or Town)

Marlboro Hospital

No. .... St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME John J. Roche a/k/a Roache  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(If deceased a U. S. War Veteran,  
specify WAR) none(a) Permanent Residence, No. .... St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 2, 1973  
(Month) (Day) (Year)4 I was last seen by CERTIFYING physician, that he attended deceased July 2, 1973  
in July 2, 1973, to July 2, 1973, I last saw him alive on July 2, 1973, death is said to  
have occurred on the date stated above, at 12:20p m.DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Cancer of rectum

(a) INTERVAL BETWEEN ONSET AND DEATH 1 yr

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

Kenneth R. Greenleaf

(Attending Physician) M.D.

Marlboro, Mass. July 2 73

(Address) Date 1973

6 Immaculate Conception, Marlboro, Mass.

Place of Burial or Cremation July 5 (City or Town) 73

DATE OF BURIAL 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St. Southboro, Mass.

Mrs. Maragret Howarth

8 Informant 30 Jericho Hill Rd. Southboro

(Address) Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word) MARRIED Single WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 77 Years 6 Months 7 Days If under 24 hours Hours Minutes

14 Usual Occupation Farmer (Kind of work done during most of working life)

15 Industry or Business Agriculture &amp; Cattleman

16 Social Security No. 023 32 8934

17 BIRTHPLACE (City) Southborough, Mass. (State or country)

18 NAME OF FATHER Martin C. Roche

19 BIRTHPLACE OF FATHER (City) Ross Common, Ireland (State or country)

20 MAIDEN NAME OF MOTHER Nora A. Gilboyle

21 BIRTHPLACE OF MOTHER (City) County Cork, Ireland (State or country)

A TRUE COPY of the original of this certificate is deposited in the files of the Registrar of the City or Town where the death occurred

ATTEST: Agent (Registrar of City or Town where death occurred)

DATE FILED July 9 1973

Received and filed July 11 1973

(Registrar of City or Town where death occurred)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



NOTE: CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SOM-8-69-045135

FORM R-303

to be filed for burial permit with Board of Health or its Agent.

7/19/73

1 PLACE OF DEATH  
Worcester (County)  
Southboro (City or Town)

2 FULL NAME  
Kevin R. Gould  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 134 Woodland Road St. Southboro, Mass.  
(City or town and State)

3 DATE OF DEATH July 14 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
Asphyxiation by suspension, suicide

5 Accident, suicide, or homicide (specify) suicide  
Date and hour of injury 19  
IF ACCIDENTAL, was injury causally related to the death?  
Where did injury occur?  
(City or town and State)  
Did injury occur in or about home, on farm, in industrial place, or in public place? While at work?  
(Specify type of place)  
Manner of injury  
(How did injury occur?)  
Nature of injury

Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signed) S. Alden Guild M.D.  
S. Alden Guild M.D.  
(Print or Type Name)  
(Address) Grafton Date July 15 1973

7 Rural cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)  
DATE July 17 1973

8 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS 40 Main St. Southboro, Mass.

Received and filed July 19, 1973

A TRUE COPY ATTEST  
Paul J. Berry, Town Clerk (Registrar)

The Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Registered No. #23

11 SINGLE (write the word)  
MARRIED Single  
WIDOWED  
DIVORCED  
UNKNOWN

9 SEX M 10 COLOR White 11 SINGLE (write the word) Single

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 44 YEARS 2 MONTHS 29 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: Student  
(Kind of work done during most of working life)

15 Industry or Business: Woodward School

16 Social Security No.

17 BIRTHPLACE (City) Framingham  
(State or country) Mass.

18 NAME OF FATHER Robert W. Gould

19 BIRTHPLACE OF FATHER (City) Marlboro  
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Clementine A. Sotir

21 BIRTHPLACE OF MOTHER (City) Marlboro  
(State or country) Mass

22 Informant Robert W. Gould  
(Address) 134 Woodland Rd. Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
Mrs. Susan A. Morcote  
(Signature of Agent of Board of Health or other)  
7/16/73  
(Official Designation) (Date of Issue of Permit)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WOBURN

(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Woburn

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #24

No. N.E. Rehabilitation Center St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME AVIS H. CUMMINGS (Marshall)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence, No. 250 Parkerville Road St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 20, 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from June 7, 1973, to July 20, 1973.  
I last saw him alive on July 19, 1973, death is said to have occurred on the date stated above, at 8:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ? Cardiac arrest

Due To (b) Arteriosclerotic heart dis.

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Old CVA

Was autopsy performed?

No

What test confirmed diagnosis?

Physical, EKG

5 Was disease or injury in any way related to occupation of deceased?

No

If so, specify

Gerald S. Harris

(Attending Physician) M.D.

(Address) Woburn Date 7/20 1973

6 Rural Cemetery, Southboro, MA.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 23 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS 40 Main St., Southboro, Mass.

8 Informant Joseph F. Cummings, Sr.  
250 Parkerville Rd., Southboro

(Address)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Married

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph F. Cummings, Sr.

(Husband's name in full)

13 AGE 78 Years 5 Months 14 Days | If under 24 hours  
Hours Minutes

14 Usual

Housewife

Occupation (Kind of work done during most of working life)

15 Industry  
or Business

At Home

16 Social Security No. 028-28-4173

17 BIRTHPLACE (City)  
(State or country)Lowell  
Mass.18 NAME OF  
FATHER

Charles L. Marshall

19 BIRTHPLACE OF  
FATHER (City)  
(State or country)Clinton  
Mass.20 MAIDEN NAME  
OF MOTHER

Louisa Hanson

21 BIRTHPLACE OF  
MOTHER (City)  
(State or country)Lowell  
Mass.

A TRUE COPY

ATTEST:

DATE FILED July 23 1973

Received and filed August 3, 1973

(Registrar or Town where deceased resided)

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #27

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)



No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME James A. Cronin

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR) No

(a) Permanent Residence, No. 46 Richards Rd.

St. Southboro, Mass.

(City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 27, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
7/13 to 7/27 7/27 1973  
I last saw him alive on 7/27 1973, death is said to  
have occurred on the date stated above, at 6:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphosarcoma

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Bone marrow

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Marvin M. Adner

M.D.

(Address) Framingham, Mass. Date 7/28 1973

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 30, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Allen F. Cronin  
(Address) Southboro, Mass.

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 9 Years 4 Months 24 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Student  
(Kind of work done during most of working life)

15 Industry or Business Mary Finn School

16 Social Security No. 17 BIRTHPLACE (City) Framingham, Mass.  
(State or country)

18 NAME OF FATHER Allen F. Cronin

19 BIRTHPLACE OF FATHER (City) Framingham, Mass.  
(State or country)

20 MAIDEN NAME OF MOTHER Dorothy Gallini

21 BIRTHPLACE OF MOTHER (City) Framingham, Mass.  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED July 31, 1973

Received and filed August 23, 1973

(Registrar of City or Town where deceased resided) Paul J. Berry, Town Clerk

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



M R-301

For burial permit  
Board of Health  
is Agent.

OR TYPE  
OR CAUSES  
DEATH  
ADJUDICATING BLACK  
APPROVED  
TYPEWRITER  
IBBON

not mean the mode of  
as heart failure, as the  
means the disease, or  
is which caused death.

is, if any, which gave  
the cause (a), stating the  
cause last.

is contributing to death  
led to the terminal dis-  
order given in (a).

OUT-OF-TOWN

Suffolk

(County)

Boston

(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 6487 #30

No. Children's Hospital Medical Center

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Heidi A. Wiedergott

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 36 Marlboro Road

St. Southboro, Massachusetts

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 1 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
July 31 1973, to August 1 1973  
I last saw her alive on August 1 1973, death is said to  
have occurred on the date stated above, at 8:15 P.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Arrhythmia

Due To Hypertension

Due To Brain Death

OTHER SIGNIFICANT CONDITIONS Seizures, coma.

Was autopsy performed? yes

What test confirmed diagnosis? pending

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Sheldon Buzney M.D.

(Print or Type Name)

(Address) 300 Longwood Ave Date 8/1 1973

6 RURAL CEMETERY SOUTH BORO

Place of Burial or Cremation

(City or Town) MASS

DATE OF BURIAL AUG 4 1973

7 NAME OF FUNERAL DIRECTOR DONALD C. MORRIS

40 MAIN ST SOUTH BORO MASS

8 Informant WILLIAM WIEDERGOTT

36 MARLBORO ROAD

SOUTH BORO MASS

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR WHITE 11 SINGLE (write the word)  
MARRIED WIDOWED SINGLE  
DIVORCED UNKNOWN

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 2 Years 2 Months 5 Days If under 24 hours  
Hours Minutes

14 Usual Occupation (Kind of work done during most of working life)

15 Industry or Business AT HOME

16 Social Security No.

17 BIRTHPLACE (City) FRAMINGHAM  
(State or country) MASS

18 NAME OF FATHER WILLIAM WIEDERGOTT

19 BIRTHPLACE OF FATHER (City) PENNSBURG  
(State or country) PENNA.

20 MAIDEN NAME OF MOTHER SYLVIA BLOCH

21 BIRTHPLACE OF MOTHER (City) SYRACUSE (BLOCH)  
(State or country) N.Y.I HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
with me BEFORE the burial or transit permit was issued.

(Signature of Agent Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

Received and filed AUG 7 1973 19

William J. Kane (Registrar)  
X TRUE COPY ATTEST:



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Worcester

(County)

Southboro

(City or Town)

## STANDARD CERTIFICATE OF DEATH

Registered No. #25

No. 26 Main

St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

### PHYSICIAN—IMPORTANT

(If deceased a U. S. War Veteran specify WAR) None

St. Southboro, Mass.  
(City or town and State)

2 FULL NAME Helen V. (Connelly) Concannon  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. 26 Main

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 8 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from March 18 1948 to August 8 1973  
I last saw her alive on May 1 1973, death is said to have occurred on the date stated above, at 7 a.m.

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Failure, acute

(b) Rheumatic Heart Disease

(c)

OTHER SIGNIFICANT CONDITIONS Asthma

Was autopsy performed? No. Med. examiner notified.

What test confirmed diagnosis? Clinical Course

5 Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signature) Timothy P. Stone, M.D.

TIMOTHY P. STONE  
(Print or Type Name)

(Address) 42 Main St, Southboro Date August 9 1973

6 Milton Cemetery Milton, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 11 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

40 Main Street Southboro, Mass.

8 Informant Walter E. Concannon

12 Strawberry Hill Road  
(Address) Southboro, Mass.

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX F 10 COLOR White 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of John M. Concannon (Husband's name in full)

13 AGE 71 Years 2 Months 15 Days | If under 24 hours Hours Minutes

14 Usual Occupation Secretary  
(Kind of work done during most of working life)

15 Industry or Business Law office

16 Social Security No. 031-18-1646

17 BIRTHPLACE (City) Dorchester  
(State or country) Mass.

18 NAME OF FATHER John Connelly

19 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Elizabeth Thompson

21 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Torcoletti  
(Signature of Agent Board of Health or other)

(Official Designation) 8/10/73  
(Date of Issue of Permit)

Received and filed August 13 1973

A TRUE COPY ATTEST Paul J. Berry, Registrar  
Town Clerk

RM R-301

ed for burial permit  
Board of Health  
r its Agent.

CTIONS FOR  
AL CERTIFICATE

NT OR TYPE  
SE OR CAUSES  
OF DEATH  
NFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
It means the disease, or  
itions which caused death.  
tions, if any, which gave  
above cause (a), stating the  
ng cause last.

tions contributing to death  
related to the terminal dis-  
tion given in (a).



01973

RM R-301

ed for burial permit  
Board of Health  
or its Agent.

STRUCTIONS FOR  
AL CERTIFICATE

NT OR TYPE  
SE OR CAUSES  
OF DEATH  
NFADING BLACK  
OR APPROVED  
K TYPEWRITER  
RIBBON

does not mean the mode of  
such as heart failure, asthe-  
. It means the disease, or  
ations which caused death.  
itions, if any, which gave  
above cause (a), stating the  
ing cause last.

itions contributing to death  
related to the terminal dis-  
dition given in (a).

# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS



(City or Town making this return)

1 PLACE OF DEATH  
Worcester  
(County)  
Southboro  
(City or Town)

STANDARD  
CERTIFICATE OF DEATH Registered No. 26

No. 34 Turnpike Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Pugni  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Permanent Residence, No. 34 Turnpike Road St. Southboro, Mass.  
(City or town and State)

## PHYSICIAN-IMPORTANT

(If deceased a  
U. S. War Veteran specify WAR) None  
None

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 14 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Aug. 12, 1973, to Aug. 14, 1973.  
I last saw him alive on Aug. 14, 1973, death is said to  
have occurred on the date stated above, at m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CIRRHOSIS  
Due To  
(b)  
Due To  
(c)

OTHER SIGNIFICANT CONDITIONS Emphysema 10yrs.

Was autopsy performed? NO

What test confirmed diagnosis? Lab & clinical

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) Garry A. Goldstein M.D.

1 Buckminster Place  
(Address) Framingham, Mass. Aug. 14, 1973

6 Rural cemetery Southboro, Mass.  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL August 17, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
40 Main Street Southboro, Mass.  
ADDRESS

8 Informant Mrs. Mable Pugni  
34 Turnpike Road  
(Address)

Southboro Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR White 11 SINGLE (write the word) MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced HUSBAND of Mable Trioli  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 74 Years 10 Months 25 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Cement Finisher  
(Kind of work done during most of working life)

15 Industry or Business Ablondi Construction

16 Social Security No. 115-07-0897 A

17 BIRTHPLACE (City) Buenos Aires  
(State or country) Argentina

18 NAME OF FATHER Guido Pugni

19 BIRTHPLACE OF FATHER (City) Piacenza  
(State or country) Italy

20 MAIDEN NAME OF MOTHER Josephine Bertussi

21 BIRTHPLACE OF MOTHER (City) Piacenza  
(State or country) Italy

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Sina A. Torcote  
(Signature of Agent Board of Health or other)

(Official Designation) 8-15-73  
(Date of Issue of Permit)

Received and filed August 20, 1973

Paul J. Berry (Registrar)

A TRUE COPY ATTEST: Town Clerk



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)Middlesex  
(County)  
Framingham

COPY OF

CERTIFICATE OF DEATH

Registered No. #28

No. Framingham Union Hospital

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

Louis Noborini

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

75 Turnpike Road

Southboro, Mass.

(a) Permanent Residence, No.

St. (City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 19 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY, that I attended deceased from August 19 1973  
I last saw him alive on August 19 1973  
have occurred on the date stated above, at 10:45pm m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

Due To ASHDCHF

Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

Mark S. Wellington

(Attending Physician) M.D.

Framingham

8/20/73

(Address) Date 19

6 Rural Cemetery, Southboro

Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 22 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.8 Informant Mrs. Mary Bezokas  
(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN  
widowed12 If married, widowed, or divorced  
HUSBAND of Mena Trioli  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)13 AGE 87 Years 2 Months 21 Days If under 24 hours  
Hours Minutes14 Usual Occupation Gardener  
(Kind of work done during most of working life)

15 Industry or Business Landscaping

16 Social Security No. 021 26 0264

17 BIRTHPLACE (City) Italy  
(State or country)

18 NAME OF FATHER Louis Noborini

19 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

20 MAIDEN NAME OF MOTHER CNBL

21 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)A TRUE COPY  
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED August 22, 1973 19

Received and filed September 10, 1973  
Paul J. Berry, Town Clerk  
(Registrar of City or Town where deceased resided)MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



11/30/73

FORM R-303

be filed for burial permit  
with Board of Health  
or its Agent.

NOTE:- CHAPTER 137, ACTS OF 1954, REQUIRES PHYSICIANS TO PRINT  
OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of  
information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF  
DEATH in plain terms, so that it may be properly classified under the International Classification of Causes  
of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114,  
§§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100B-3-67-944817

PLACE OF DEATH

Worcester

(County)

Southborough

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. #38

State Highway (Rte 9) Southborough

Michael D. Korsak

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

2 FULL NAME (First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. Worcester State Hospital, Worcester, Mass.

City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 23, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Fractured skull and brain laceration  
when accidentally struck by automobile  
while walking on Highway (rte 9)  
in Southborough, Mass. Accident

5 Accident, suicide, or homicide (specify) Accident  
Date and hour of injury 8:15 P.M. Aug. 23, 73

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did  
injury occur? Southborough, Mass.  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? State Highway  
(Specify type of place)

Manner of  
injury Struck by car on public highway  
(How did injury occur?)

Nature of  
injury Multiple injuries inclu. fractured  
skull

While at work? No. Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) S. Aiden Guild M.D.  
(Print or Type Name)

(Address) Grafton Date Aug 28, 1973

7 Bethany Cemetery  
Place of Burial or Cremation, (City or Town)

DATE OF BURIAL Aug. 30, 1973

8 NAME OF FUNERAL DIRECTOR Kenneth C. Roberge  
ADDRESS Palmer, Mass.

Received and filed November 30, 1973

A TRUE COPY Paul J. Berry, Town Clerk

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR White 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

WIFE of (Husband's name in full)

13 AGE 17 Years 10 Months 16 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: Student  
(Kind of work done during most of working life)

15 Industry or Business: Palmer School System

16 Social Security No. 033-41-0780

17 BIRTHPLACE (City) Palmer, Massachusetts  
(State or country)

NAME OF FATHER John Korsak  
~~Robert Korsak~~

PLACE OF FATHER (City) Unknown  
(State or country) ~~Mass.~~

20 MAIDEN NAME OF MOTHER Dorothy Callahan

21 BIRTHPLACE OF MOTHER Manson, Mass.  
(State or country)

22 Informant Dorothy C. Vassos  
(Address) Colonial Pk. Apts. Apt. 36  
Three Rivers, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

David J. Myerson DAVID J. MYERSON  
(Signature of Agent of Board of Health or other)

Worcester State Hospital  
(Official Designation) (Date of Issue of Permit) 8/29/73



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)

PLACE OF DEATH

Middlesex  
(County)

Framingham  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. #29

No. Framingham Nursing Home

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME James G. Stockwell  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran, No  
specify WAR)  
Southboro, Mass.  
(City or town and State)

(a) Permanent Residence, No. 246 Parkerville Rd.

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 31, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
Oct. 8, 1971, to Aug. 31, 1973.  
I last saw em. alive on Aug. 31, 1973; death is said to  
have occurred on the date stated above, at 9:40p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
(a) Lymphoblastic lymphosarcoma

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
1 Mo.

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS Generalized arteriosclerosis

10Yrs.

Was autopsy performed? No

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Herbert M. Levenson, M.D.

(Address) Framingham, Mass. Date 8/31, 1973

6 Rural Cem., Southboro, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 3, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris  
ADDRESS Southboro, Mass.

8 Informant Mrs. Albert Ward  
(Address) Ashland, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED WIDOWED Widowed  
DIVORCED UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of Minnie R. LeGay  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

13 AGE 91 Years 4 Months 14 Days If under 24 hours  
Hours Minutes

14 Usual Occupation Bookkeeper  
(Kind of work done during most of working life)

15 Industry or Business United Shoe Mach. Co.

16 Social Security No. 013-01-4540

17 BIRTHPLACE (City) Warwick, Mass.  
(State or country)

18 NAME OF FATHER Frank P. Stockwell

19 BIRTHPLACE OF FATHER (City) Framingham, Mass.  
(State or country)

20 MAIDEN NAME OF MOTHER Leonora H. Chapin

21 BIRTHPLACE OF MOTHER (City) Orange, Mass.  
(State or country)

A TRUE COPY

ATTEST: Michael J. Ward  
(Registrar of City or Town where death occurred)

DATE FILED Sept. 4, 1973

Received and filed September 10, 1973

(Registrar of City or Town where death occurred)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



2224

I R-301

or burial permit  
rd of Health  
Agent.

TIONS FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH  
ADING BLACK  
APPROVED  
TYPEWRITER  
BBON

not mean the mode of  
as heart failure, asthe-  
means the disease, or  
which caused death.

, if any, which gave  
cause (a), stating the  
cause last.

contributing to death  
ed to the terminal dis-  
n given in (a).

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Worcester  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 2235

PLACE OF DEATH

Worcester  
(County)

Worcester  
(City or Town)



No. Doctors Hospital of Worcester

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Georgianna Gartner (Dugrenien)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran,  
specify WAR) No

(a) Permanent Residence. No. 1 Lynbrook Road

St. Southboro, Massachusetts  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 4 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from 8-26 1973, to 9-4 1973.  
I last saw her alive on 9-4 1973, death is said to  
have occurred on the date stated above, at 2:25 a.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory Failure

Due To

(b) Pulmonary Acidosis

Due To

(c) Cardiac Arrhythmia

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Michael Manoogian, M.D.

(Address) 311 Main Street Date 9-4 1973

6 Worcester County Mem. Park, Boston, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 6 1973

7 NAME OF FUNERAL DIRECTOR D.J. Mills For F.H. Mills Co

ADDRESS 1158 Main St. Holden, Mass.

8 Informant Self

(Address)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN Widowed

12 If married, widowed, or divorced  
HUSBAND of

(or) WIFE of Charles A. Gartner  
(Give maiden name of wife in full)  
(Husband's name in full)

13 AGE 75 Years 2 Months 22 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At Home

16 Social Security No. 014-28-3256

17 BIRTHPLACE (City) UNKNOWN Canada  
(State or country)

18 NAME OF FATHER Joseph Dugrenier

19 BIRTHPLACE OF FATHER (City) UNKNOWN Canada  
(State or country)

20 MAIDEN NAME OF MOTHER Mary - (UNKNOWN)

21 BIRTHPLACE OF MOTHER (City) UNKNOWN Canada  
(State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed  
with me BEFORE the burial or transit permit was issued:

(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit)

Received and filed Commissioner of Public Health

SEP 19 1973

A TRUE COPY ATTEST:

Robert J. O'Keefe (Registrar)

TOWN OF SOUTHBOROUGH

OCT 2 1973

01. 150M-3-72-051297



## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSFramingham  
(City or Town making this return)COPY OF  
CERTIFICATE OF DEATH

Registered No. #31

Middlesex

(County)

Framingham

(City or Town)

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT2 FULL NAME Eleanor K. Peck (Langill)  
(If deceased is a married, widowed or divorced woman, give also maiden name.){ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. 14 Middle Rd.

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 20, 1973  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from  
Dec. 22, 1973 to Sept. 20, 1973  
I last saw her alive on Sept. 20, 1973 death is said to  
have occurred on the date stated above, at 2:20 P.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma, bladder

Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

No

Was autopsy performed? No  
What test confirmed diagnosis? Surgery, biopsy5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 9/20 1973

6 Cambridge Cem., Cambridge, Mass.  
(City or Town)

DATE OF BURIAL Sept. 22, 1973

7 NAME OF FUNERAL DIRECTOR Guy H. Harmish  
Cambridge, Mass.  
ADDRESS8 Informant David L. Truesdale  
(Address) Worcester, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED Divorced  
UNKNOWN12 If married, widowed, or divorced  
HUSBAND of(or) WIFE of Everett L. Peck, Sr.  
(Give maiden name of wife in full)  
(Husband's name in full)13 AGE 82 Years Months Days If under 24 hours  
Hours Minutes14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business Own home

16 Social Security No.  
17 BIRTHPLACE (City) Cambridge, Mass.  
(State or country)

18 NAME OF FATHER Robinson A. Langill

19 BIRTHPLACE OF FATHER (City) Canada  
(State or country)

20 MAIDEN NAME OF MOTHER Emma Dwyer

21 BIRTHPLACE OF MOTHER (City) Canada  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Sept. 24, 1973

Received and filed October 18, 1973

Paul D. Berry  
(Registrar of City or Town where deceased resided)MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham

(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #35

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Beatrice R. Miller (McLaughlin)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence, No. 187 Parkerville Rd.

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 15, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
May 4, 1968, to Oct. 15, 1973.  
I last saw her alive on Oct. 15, 1973. death is said to  
have occurred on the date stated above, at 2:10 P.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolism

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS Arteriosclerotic  
heart disease

INTERVAL  
BETWEEN  
ONSET AND  
DEATH:  
45 mins.

Was autopsy performed? No

What test confirmed diagnosis? In hospital observation

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Attending Physician) Timothy P. Stone, M.D.

(Address) Southboro, Mass. Date 10/17/73

6 Rural Cem., Southboro, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 19, 1973

7 NAME OF FUNERAL DIRECTOR Donald C. Morris

ADDRESS Southboro, Mass.

8 Informant Dorothy R. Walsh

(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED Widowed  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Louis Miller  
(Husband's name in full)

13 AGE 72 Years 10 Months 10 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Housewife  
(Kind of work done during most of working life)

15 Industry or Business At home

16 Social Security No. 013 07 1980

17 BIRTHPLACE (City) Boston, Mass.  
(State or country)

18 NAME OF FATHER James McLaughlin

19 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

20 MAIDEN NAME OF MOTHER Ellen Callahan

21 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Oct. 23, 1973

Received and filed November 12, 1973

(Registrar of City or Town where deceased resided)



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

SOUTHBORO  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. #32

WORCESTER  
(County)

SOUTHBORO  
(City or Town)

No. 52 A Main Street

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME HARRISON L. REINKE  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) NO

(a) Permanent Residence, No. 52 A MAIN

St. SOUTHBORO, MASS.  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 18, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from August 16, 1948, to October 18, 1973.  
I last saw him alive on October 18, 1973, death occurred on the date stated above, at 7:40 a.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction

(b) Coronary Occlusion

(c) Arteriosclerotic Heart Disease

13 1/4 hrs.

1 mo.

13 yrs.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? ECG, Chest X-ray, Observation

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Timothy B. Stone, M.D.

42 MAIN ST. (Print or Type Name)  
(Address) SOUTHBORO, MA. Date OCT. 18, 1973

6 NEWTON CREMATORY, NEWTON, MASS.

Place of Burial (City or Town)

DATE OF BURIAL OCTOBER 20, 1973

7 NAME OF EUNERIAL DIRECTOR ROBERT K. WADSWORTH  
108 LINCOLN ST. FRAMINGHAM, MASS.  
ADDRESS

8 Informant Mrs. ELIZABETH L. REINKE (wife)  
52A MAIN ST., SOUTHBORO, MASS.  
(Address)

ZIP. 01772.

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR WHITE 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of ELIZABETH LABAREE

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 68 Years 2 Months 21 Days If under 24 hours Hours Minutes

14 Usual Occupation EDUCATOR - Retired  
(Kind of work done during most of working life)

15 Industry or Business PRIVATE SCHOOLS

16 Social Security No. 013-16-7870

17 BIRTHPLACE (City) PHILADELPHIA, PENNA.  
(State or country)

18 NAME OF FATHER EDWIN JOSEPH REINKE

19 BIRTHPLACE OF FATHER C.N.B.L. PROV. = ONTARIO, CANADA  
(State or country)

20 MAIDEN NAME OF MOTHER EMILY KNAUSS

21 BIRTHPLACE OF MOTHER BATH, PENNA.  
(State or country)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan A. Torcok, Agent  
(Signature of Agent Board of Health or other)

(Official Designation) (Date of Issue of Permit) 10/19/73

Received and filed October 23, 1973

A TRUE COPY ATTEST: Paul J. Berry, Town Clerk



R-303 11/5/73

for burial permit  
Board of Health  
Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

PLACE OF DEATH

Worcester

(County)

Southboro

(City or Town)

The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSMEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. #34

No. DOA Marlboro Hospital

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME David Charles Goldstein

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Permanent Residence. No. 878 Concord Rd  
(Usual place of abode)St. Marlboro  
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 31 1973  
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
Massive skull fracture, automobile accident.5 Accident, suicide, or homicide (specify) Accident  
Date and hour of injury Oct. 31, 19 73IF ACCIDENTAL, was injury causally related to the death? yesWhere did injury occur? Southboro, Mass.  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? Framingham Rd. (Public Place)  
(Specify type of place)Manner of injury Accidental  
(How did injury occur?)Nature of injury See aboveWhile at work? ..... Was autopsy performed? no6 Was disease or injury in any way related to occupation of deceased? noIf so, specify See above(Signed) Luke G. Tedeschi, M. D.  
(Print or Type Name)(Address) Hopedale Cemetery Hopedale Mass  
(City or Town)DATE OF BURIAL Nov 3, 19738 NAME OF FUNERAL DIRECTOR GEORGE TERLMANADDRESS 1026 MAIN ST WORCESTERReceived and filed November 5, 1973A TRUE COPY ATTEST: J. Berry, (Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single12 If married, widowed, or divorced  
HUSBAND of .....  
(Give maiden name of wife in full)(or) WIFE of .....  
(Husband's name in full)13 AGE 4 Years 4 Months 5 Days If under 24 hours  
Hours ..... Minutes14 Usual Occupation: NONE  
(Kind of work done during most of working life)15 Industry or Business: NONE16 Social Security No. Marlboro, Mass.  
BIRTHPLACE (City) (State or country)18 NAME OF FATHER SPENCER Goldstein19 BIRTHPLACE OF FATHER (City) TACOMA PARK, MARYLAND  
(State or country)20 MAIDEN NAME OF MOTHER Eloise, Phillips21 BIRTHPLACE OF MOTHER (City) Milford, Mass.  
(State or country)22 MRS. ELAINE SANRICANDRO (AUNT)  
Informant (Address)100 Mill St, Hopedale, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Mrs. Sena A. Locatelli  
(Signature of Agent of Board of Health or other)11/1/73  
(Date of Issue of Permit)



RM R-303

for burial permit  
Board of Health  
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-70-047760

PLACE OF DEATH

Worcester

(County)

Southboro

(City or Town)



The Commonwealth of Massachusetts

JOHN F. X. DAVOREN

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

**MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH**

Registered No. #36

No. 14 Deerfoot Road

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME

Harry

(First Name)

Onufrock

(Middle Name)

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR)

None

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 14 Deerfoot Road

St. Southboro, Mass.

(City or town and State)

**MEDICAL CERTIFICATE OF DEATH**

3 DATE OF  
DEATH

Nov. 6

(Month)

1973

(Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Accidental due to cardiac arrest  
resulting from electric shock  
by contacting exposed electric  
wiring.

5 Accident, suicide, or homicide (specify)

Accident

Date and hour of injury 6:15 PM 6 Nov 1973

IF ACCIDENTAL, was injury causally related to the death? YES

Where did injury occur? Southborough, Mass.

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? cellar of home. While at work? NO

(How did injury occur?)

Manner of injury Electrocuted in home

(Specify type of place)

Nature of injury Electrocution

(Specify type of place)

Was autopsy performed? NO

Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) S. Allen Gould M.D.

(Print or Type Name)

(Address) 621 N. Main St. Date Nov 6 1973

6 Rural Cemetery Southboro, Mass.

Place of Burial or Cremation

(City or Town)

DATE Nov. 10, 1973

7 NAME OF  
FUNERAL DIRECTOR

Donald C. Morris

40 Main Street Southboro, Mass.

ADDRESS

8 Informant Mrs. Helen M. Onufrock

14 Deerfoot Road Southboro, Mass.

(Address)

**PERSONAL AND STATISTICAL PARTICULARS**

9 SEX

10 COLOR

11 SINGLE

(write the word)

M

White

MARRIED

WIDOWED

DIVORCED

UNKNOWN

12 If married, widowed or divorced  
HUSBAND of Helen M. Moore

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 62 YEARS 11 MONTHS 21 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: Business Manager

(Kind of work done during most of working life)

15 Industry or Business: Marlboro-Westboro Mental  
Health Clinic

16 Social Security No. 324-01-3408

17 BIRTHPLACE (City) Colorado Springs  
(State or country) Colorado

18 NAME OF

FATHER Aleck John Onufrock

19 BIRTHPLACE OF

FATHER (City) CNBL

(State or country) Czechoslovakia

20 MAIDEN NAME

OF MOTHER Anna Robbins

21 BIRTHPLACE OF

MOTHER (City) Pittston

(State or country) Penna.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Mrs. Susan A. ...  
(Signature of Agent Board of Health or other)

(Official Designation)

(Date of issue of Permit)

Received and filed November 13, 1973

Paul J. Berry (Registrar)  
A TRUE COPY ATTEST Paul J. Berry, Town Clerk







SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE January 4, 1957.....

DATE OF DISCHARGE December 12, 1958.....

RANK, RATING .....

ORGANIZATION AND OUTFIT Army.....?.....

SERVICE NUMBER 51-395-535.....

---

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

Medical Examiners will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

#### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile" "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

If the cause of death has not been determined at the time of the certification, item #4 should be noted "Undetermined — pending further investigation."

Immediately upon the completion of the investigation, a new form R-303 should be complete insofar as the medical portion is concerned (Items #1 through #6) signed and filed with the local clerk so that the original return may be completed by adding the cause of death to it.



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON —  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Framingham  
(City or Town making this return)



PLACE OF DEATH

Middlesex

(County)

Framingham

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #39

No. Framingham Union Hospital

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
PHYSICIAN—IMPORTANT

2 FULL NAME Paul Douglas Bragg  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a  
U. S. War Veteran, No  
specify WAR)

(a) Permanent Residence, No. 99 Pine Hill Rd.

St. Southboro, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 16, 1973  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from  
1966 to Nov. 16, 1973.  
I last saw him alive on Nov. 16, 1973 death is said to  
have occurred on the date stated above, at 8:15p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute renal failure

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS Chronic refractory  
anemia

Was autopsy performed? yes  
What test confirmed diagnosis? Clinical & lab.

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Attending Physician) Garry A. Goldstein, M.D.

(Address) Framingham, Mass. Date 11/17 1973

6 Newton Crematory, Newton, Mass.

Place of Burial or Cremation

(City or Town) Nov. 19, 1973

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Edmund H. Tunnicliffe  
ADDRESS Framingham, Mass.

8 Informant Margaret E. Harrison

(Address) Southboro, Mass.

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Widowed

12 If married, widowed, or divorced  
HUSBAND of Evelyn Birnie  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

13 AGE 79 Years 4 Months 7 Days | If under 24 hours  
Hours Minutes

14 Usual Occupation Superintendent-retired  
(Kind of work done during most of working life)

15 Industry or Business Eastligh Farms

16 Social Security No. 017 26 1013

17 BIRTHPLACE (City) Canada  
(State or country)

18 NAME OF FATHER William Bragg

19 BIRTHPLACE OF FATHER (City) Canada  
(State or country)

20 MAIDEN NAME OF MOTHER Josephine Ambrose

21 BIRTHPLACE OF MOTHER (City) Canada  
(State or country)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Nov. 19, 1973

Received and filed December 10, 1973

Paul J. Berry, Town Clerk  
(Registrar of City or Town where deceased resided)



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON -  
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

1 PLACE OF DEATH

**Middlesex**

(County)

**Framingham**

(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. #40

No. **Framingham Union Hospital**

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
**PHYSICIAN-IMPORTANT**

2 FULL NAME **Winifred Mary Tucker (Villiers)**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence, No. **30 Sears Rd.**

St. **Southboro, Mass.**  
(City or town and State)

MEDICAL CERTIFICATE OF DEATH		PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH	<b>November 19 1973</b> (Month) (Day) (Year)	9 SEX	10 COLOR
4 I HEREBY CERTIFY, that I attended deceased from	<b>11-14-73</b> to <b>11-19-73</b>	<b>F</b>	<b>W</b>
I last saw her alive on <b>11-19-73</b>	death is said to have occurred on the date stated above, at <b>3:09</b> m.	11 SINGLE (write the word) <b>MARRIED</b> WIDOWED DIVORCED UNKNOWN	<b>Married</b>
DEATH WAS CAUSED BY: IMMEDIATE CAUSE		12 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of <b>Lawrence E. Tucker</b> (Husband's name in full)	
(a) <b>Acute hemorrhagic pancreatitis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 dys</b>	13 AGE <b>71</b> Years <b>4</b> Months <b>4</b> Days	If under 24 hours Hours Minutes
Due To (b)		14 Usual Occupation <b>Storekeeper</b>	(Kind of work done during most of working life)
Due To (c)		15 Industry or Business <b>Dairy Store</b>	
OTHER SIGNIFICANT CONDITIONS		16 Social Security No. <b>016-24-4828</b>	
Was autopsy performed? <b>yes</b>		17 BIRTHPLACE (City) (State or country) <b>Ireland</b>	
What test confirmed diagnosis?		18 NAME OF FATHER <b>Thomas Villiers</b>	
5 Was disease or injury in any way related to occupation of deceased? <b>no</b>		19 BIRTHPLACE OF FATHER (City) (State or country) <b>Ireland</b>	
If so, specify		20 MAIDEN NAME OF MOTHER <b>Mary London</b>	
<b>Jeremiah O. Young</b> (Attending Physician) M.D.		21 BIRTHPLACE OF MOTHER (City) (State or country) <b>Ireland</b>	
(Address) <b>Framingham</b> Date <b>11-19-73</b>		PARENTS	
6 <b>Fox Hill Cemetery</b> Place of Burial or Cremation (City or Town)	<b>Billerica</b>	A TRUE COPY	
DATE OF BURIAL <b>November 23 1973</b>		ATTEST: <i>[Signature]</i> (Registrar of City or Town where death occurred)	
7 NAME OF FUNERAL DIRECTOR <b>Perry Funeral Serv.</b>	<b>Billerica</b>	DATE FILED <b>11-26-73</b>	
ADDRESS		Received and filed <b>December 10, 1973</b> <i>[Signature]</i> <b>Paul J. Berry</b> (Registrar of City or Town where deceased resided)	
8 Informant <b>Lawrence E. Tucker</b>	<b>Southboro, Mass.</b>		
(Address)			



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**Framingham**  
(City or Town making this return)

**Middlesex**

(County)

**Framingham**

(City or Town)



COPY OF

CERTIFICATE OF DEATH

Registered No.

#41

No. **Framingham Union Hospital**

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)  
**PHYSICIAN—IMPORTANT**

2 FULL NAME **Peter V. Johnson**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (If deceased a  
U. S. War Veteran,  
specify WAR)

(a) Permanent Residence. No.

**47 Oregon Rd.**

St.

**Southboro, Mass.**

(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **November 23 1973**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that I attended deceased from **August 73** to **11-23 73**  
I last saw him alive on **11-23 73** death is said to  
have occurred on the date stated above, at **3:00p.m.**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Arteriosclerotic thoracic unde-**  
**Terminated Aortic Aneurysm**

Due To  
(b)  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS **Myocardiopathy**

Was autopsy performed? **no**  
What test confirmed diagnosis? **Surgery**

5 Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify

**Robert V. Libertini**  
(Attending Physician) M.D.

(Address) **Framingham** Date **11-24 73**

6 **Rural Cemetery** **Southboro**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **November 26 1973**

7 NAME OF FUNERAL DIRECTOR **Donald C. Morris**  
ADDRESS **Southboro, Mass.**

8 Informant **Mrs. Peter Johnson**  
(Address) **Southboro, Mass.**

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **M** 10 COLOR **W** 11 SINGLE (write the word)  
MARRIED **Married**  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, divorced  
HUSBAND of **Ruth Kilpatrick**  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

13 AGE **56** Years **2** Months **29** Days | If under 24 hours  
.....Hours.....Minutes

14 Usual Occupation **Veterinarian**  
(Kind of work done during most of working life)

15 Industry or Business **Oak Knoll Kennels**

16 Social Security No. **032-12-5309**

17 BIRTHPLACE (City) **Newton**  
(State or country) **Mass.**

18 NAME OF FATHER **Robert H. Johnson**

19 BIRTHPLACE OF FATHER (City) **Newton**  
(State or country) **Mass.**

20 MAIDEN NAME OF MOTHER **Ilma Sessions**

21 BIRTHPLACE OF MOTHER (City) **Whittier**  
(State or country) **Calif.**

A TRUE COPY

ATTEST: **Michael J. Wood**  
(Registrar of City or Town where death occurred)

DATE FILED **11-26-73**

Received and filed **December 10, 73**

**Paul J. Berry**  
(Registrar of City or Town where deceased resided)



# The Commonwealth of Massachusetts

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

**BOSTON**

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **10279** #43

PLACE OF DEATH  
**SUFFOLK**  
(County)  
**BOSTON**  
(City or Town)



No. **Massachusetts General Hospital - PHILLIPS HOUSE** St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT

2 FULL NAME **Allen K. Kassay**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If deceased a U. S. War Veteran, specify WAR) **NONE**

(a) Permanent Residence. **7 Strawberry Hill, Southboro** St. **Mass.**  
(City or town and State)

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 9, 1973**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, that we attended deceased from **12/8/73** to **12/9/73**  
deceased saw him alive on **2/9/73**, death is said to have occurred on the date stated above, at **3:15 a.m.** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Aortic Dissection**

Due To  
(b)

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS **S/P Aortic Valve Replacement**  
**Calcific Aortic Stenosis** years

Was autopsy performed? **yes**

What test confirmed diagnosis? **clinical**

5 Was disease or injury in any way related to occupation of deceased?

If so, specify **Thomas S. Durant**

(Signature) **Thomas S. Durant, M.D.** M.D.

(Address) **Ass't Dir., Mass. Gen'l Hospital** 19

6 **RURAL CEMETERY SOUTHBORO, MA.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **DEC 12,** 19**73**

7 NAME OF FUNERAL DIRECTOR **DONALD C MORRIS**  
**40 MAIN ST. SOUTH BORO MASS**  
ADDRESS

8 Informant **SYLVIA A. KASSAY**  
(Address) **17 STRAWBERRY HILL ROAD**  
**SOUTHBORO, MASS**

### PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Male** 10 COLOR **WHITE** 11 SINGLE (write the word) **MARRIED**  
MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of **SYLVIA A. COUTTS**  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE **45** Years **0** Months **12** Days | If under 24 hours  
Hours Minutes

14 Usual Occupation **VICE PRESIDENT**  
(Kind of work done during most of working life)

15 Industry or Business **NORTON CO. WORC. MASS**

16 Social Security No. **021-268-546**

17 BIRTHPLACE (City) **PECS**  
(State or country) **HUNGARY**

18 NAME OF FATHER **DEZSO KASSAY.**

19 BIRTHPLACE OF FATHER (City) **CLUE**  
(State or country) **HUNGARY.**

20 MAIDEN NAME OF MOTHER **ELISABETH GENERICH**

21 BIRTHPLACE OF MOTHER (City) **CNAB**  
(State or country) **HUNGARY.**

22 I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Thomas S. Durant** (Signature of Agent Board of Health or other)

(Official Designation) **Dec 9, 1973** (Date of Issue of Permit)

Received and filed **DEC 13 1973**

**Thomas S. Durant** (Registrar)

A TRUE COPY ATTEST:

R-301

burial permit  
d of Health  
Agent.

IONS FOR  
ERTIFICATE

OR TYPE  
R CAUSES  
EATH  
DING BLACK  
APPROVED  
FEWRITER  
BON

not mean the mode of  
is heart failure, asthe-  
means the disease, or  
which caused death.

if any, which gave  
cause (a), stating the  
use lost.

contributing to death  
d to the terminal dis-  
given in (a).

eral Director

ease use only

BLACK Ink.  
150M-9-72-070287

95.9  
70



#2998  
1/29/74  
M R-301

For burial permit  
and of Health  
to Agent.

CTIONS FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH  
ADING BLACK  
APPROVED  
TYPEWRITER  
IBBON

is not mean the mode of  
as heart failure, asthet  
means the disease, or  
ns which caused death.  
is, if any, which gave  
re cause (a), stating the  
cause last.

is contributing to death  
ated to the terminal dis-  
ion given in (a).

1/28/74

96

PLACE OF DEATH

Worcester  
(County)  
Worcester  
(City or Town)



Commonwealth of Massachusetts  
JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Worcester  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

3124 #44

Registered No.

No. Worcester City Hospital H2125 St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN-IMPORTANT

2 FULL NAME Marilyn M. Abraham (If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Permanent Residence, No. 15 Ted Lane St. Southboro, Mass. (If deceased is U. S. War Veteran, specify WAR) no (City or town and State)

MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS			
3 DATE OF DEATH	12	13	1973	9 SEX	10 COLOR	11 SINGLE (write the word)
	(Month)	(Day)	(Year)	Female	White	MARRIED
4 I HEREBY CERTIFY, that attempted deceased 79 am			12 If married, widowed, or divorced			
12/12/1973			HUSBAND of (Give maiden name of wife in full)			
I last saw ER... alive on 12/13/1973, death is said to have occurred on the date stated above, at 6:40 a.m.			(or) WIFE of James E. Abraham (Husband's name in full)			
DEATH WAS CAUSED BY: IMMEDIATE CAUSE			13 AGE 34 Years 4 Months 13 Days   If under 24 hours			
(a) Myocardial infarction			Hours Minutes			
Due To (b)			14 Usual Occupation Teacher (Kind of work done during most of working life)			
Due To (c)			15 Industry or Business Worcester Public Schools			
OTHER SIGNIFICANT CONDITIONS bronchopneumonia (secondary) yes			16 Social Security No.			
Was autopsy performed? yes			17 BIRTHPLACE (City) Worcester, Mass. (State or country)			
What test confirmed diagnosis? autopsy			18 NAME OF FATHER Philip T. Peters			
5 Was disease or injury in any way related to occupation of deceased? no			19 BIRTHPLACE OF FATHER (City) Worcester, Mass. (State or country)			
If so, specify:			20 MAIDEN NAME OF MOTHER Margaret Smith			
(Signature) George M. Joseph M.D.			21 BIRTHPLACE OF MOTHER (City) Worcester, Mass. (State or country)			
(Address) 14 Oxford St. Date 12/13/1973			22 I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:			
6 Notre Dame Cemetery, Worcester, Mass. Place of Burial or Cremation (City or Town)			Signature of Agent Board of Health or other (Official Designation) (Date of Issue of Permit) 12-14-73			
DATE OF BURIAL December 17, 1973			23 Received and filed Commissioner of Public Health 19			
7 NAME OF FUNERAL DIRECTOR Adelard G. Morin			DEC 14 1973			
ADDRESS Worcester, Mass.			A TRUE COPY ATTEST: Robert J. O'Keefe (Registrar)			
8 Informant James E. Abraham						
(Address) 15 Ted Lane, Southboro, Mass.						



## The Commonwealth of Massachusetts

Westborough

Worcester

(County)

JOHN F. X. DAVOREN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Westborough

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. #42

No. Westborough State Hospital

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME John C. Hingston

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Permanent Residence. No. 6 Clifford Rd. St. Southborough, Mass.  
(City or town and State)

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH December 23, 1973  
(Month) (Day) (Year)8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN4 I HEREBY CERTIFY, That I attended deceased from  
Nov. 11, 1973 Dec. 23, 1973  
I last saw him alive on Dec. 23, 1973 death is said to  
have occurred on the date stated above, at 12:45 P.M.11 If married, widowed, or divorced Avis L. Nicholson  
HUSBAND OF  
(Give maiden name of wife in full)DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
BronchopneumoniaINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
2 days

(a)

Due To Chronic Suppurative  
(b) Bronchitis

2 yrs.

Due To Scleroemphysema  
(c)

10 yrs.

OTHER  
SIGNIFICANT  
CONDITIONS Chronic Cardiorespiratory  
insufficiency 8 yrs  
no12 AGE 75 Years 5 Months 11 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Janitor (retired)  
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 030-26-3811

16 BIRTHPLACE (City) Saugus,  
(State or country) Mass.

17 NAME OF FATHER Richard Hingston

18 BIRTHPLACE OF FATHER (City) Lynn,  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary McCulloch

20 BIRTHPLACE OF MOTHER (City) Lewiston,  
(State or country) MaineWas autopsy performed? Clinical  
What test confirmed diagnosis? no5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Attending Physician) M. D.

Spyridon Mazanitis, M.D.  
Westboro State Hospital Date Dec. 23, 19736 St. Joseph's Cem., Lynn  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 12-27 1973

7 NAME OF FUNERAL DIRECTOR William J. Landergan

ADDRESS 40 Nahant St., Lynn

Received and filed January 29, 1974  
Paul J. Berry

(Registrar of City or Town)

21 Informant Westborough State Hospital  
medical records &  
(Address) Funeral Director

A TRUE COPY

ATTEST: Elizabeth M. Balow  
(Registrar of City or Town where death occurred)

DATE FILED December 27, 1973